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Test Book

Advanced Course for Federal Agency Compensation Specialists

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U.S. Department of Labor
Employment Standards Administration
Federal Employees' Compensation Program
1986

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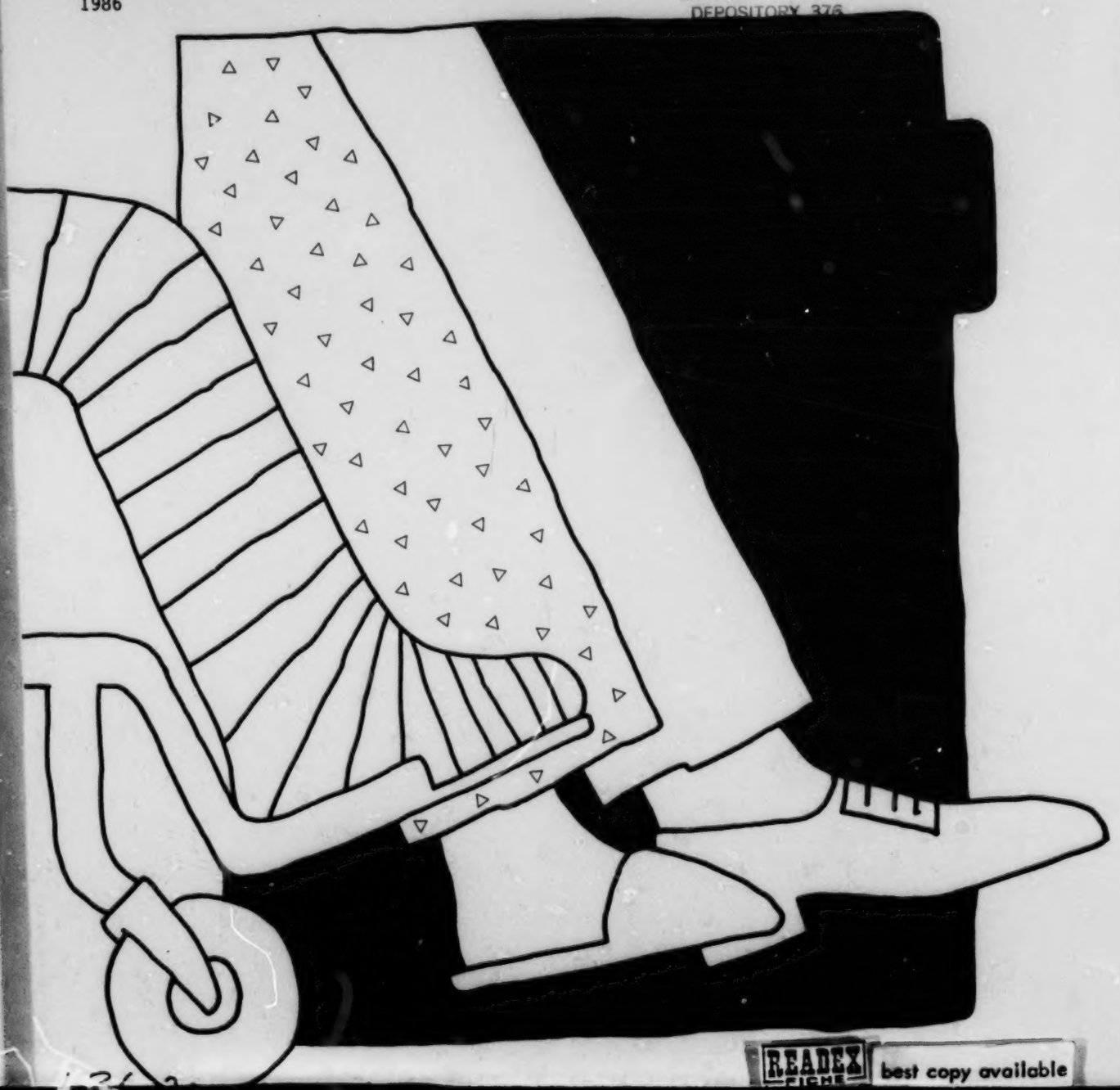

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Test Book

Advanced Course for Federal Agency Compensation Specialists

U.S. Department of Labor
Employment Standards Administration
Federal Employees' Compensation Program
1986

Performance Test

INTRODUCTION:

This is a performance test based on the kinds of skills and judgements taught in the FECA Advanced Course for Agency Compensation Specialists. The primary purpose of this test is to see how well this course enables compensation specialists to learn to make judgements related to case management of injury compensation.

The test will be identified with a code number. This is designed to protect the anonymity of course participants while still permitting the comparison of individual test scores with questionnaire responses. We are interested in evaluating the training, not the course participants.

INSTRUCTIONS:

If you are taking this test prior to completing the course, turn to page 111 and tear out the Answer Sheet for the Pre Test.

If you are taking this test after completing the course, turn to page 112 and tear out the Answer Sheet for the Post Test.

Write the last six digits of your Social Security number in the space on your test ANSWER SHEET that asks for this information. Complete the rest of the information at the top of the ANSWER SHEET.

The test is comprised of a series of cases with one or more tasks. Each task will ask you to answer a question or select the best of several possible answers. Indicate your answer on the ANSWER SHEET provided by marking an X in the space to the right of the letter which represents the answer you think is best.

Although the volume of paper for this test looks appalling, the majority of the paper represents case file contents. There are less than 35 test questions. To complete the test will take you between 1 1/2 and two hours.

Work individually.

Read and answer each question carefully. Do as well as you can.

Turn the page and begin the test.

PERFORMANCE TEST
INNER CASE
TASK I

Review the CA-1 form on the following page. Then turn to page 5 and answer the questions.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee *(Last, first, middle)*	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
Inner, Thomas E	2-1-30		151-26-8034

5. Employee's Home Mailing Address *(No., street, city, state, zip code)*	6. Home Telephone
2 South Chase Street Baltimore MD 21230	Area Code: 301 Number: 962-4011

7. Name and Address of Employing Agency	8. Place Where Injury Occurred *(e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)*
Pikesville Post Office 2 Slade Avenue Baltimore MD 21210-9998	16 Park Heights Avenue

9. Date and Hour of Injury *(mo., day, year)*	10. Date of This Notice *(mo., day, year)*	11. Dependents	12. Employee's Occupation
3:15 2/1/83 ☐ AM ☑ PM	3/2/83	Wife/Husband ☑ Children Under 18 Years Old ☑	Letter Carrier

13. Cause of Injury *(Describe how and why the injury occurred)*	14. Nature of Injury *(Identify the part of the body injured, e.g., fractured left leg, etc.)*
Slipped on wet object and fell on fence	fractured ribs

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Phyllis E Inner for Thomas
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness *(Describe what you saw, heard or know about this injury)*

None

18. Witness' Signature	19. Witness' Address	20. Date Signed *(mo., day, year)*

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
USPS	P. Rosville Branch

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
I.C.U 900 E Fayette St
Baltimore, Md 21233-7408. Rm 217

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 7:30 ☑ AM ☐ PM Ends 4:00 ☐ AM ☑ PM	8	S (M) T W T F S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
3/1/83 3:15 ☐ AM ☑ PM	3/2/83	3/1/83 4:00 PM	N/A

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor at Time of Injury
2/2/83	$ 24.044 per _____	HAS NOT Returned ☐ AM ☐ PM	John Doerr

35. Was Employee in Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee is Disabled For Work?
3/1/83	Franklin Square Hospital 9 School Rd Balto MD 21208	☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.
As presented by the employee's wife

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions
☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder
☑ Medical Expense Incurred or Expected. Forward this Form to OWCP
☑ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor	46. Title and Office Phone Number	47. Date *(mo., day, year)*
John Doerr	Supv, Delivery 922-4076	3/4/83

PERFORMANCE TEST
INNER CASE
TASK I

1. Select the choice below that reflects the most serious omission. Mark your answer on the Answer Sheet.

   a. The CA-1 does not contain the employee's signature.

   b. The CA-1 contains no explanation by the supervisor of how the accident occurred.

   c. The claimant's description of injury is incomplete.

PERFORMANCE TEST
INNER CASE
TASK II

Examine the following CA-20 then answer the question on page 8.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS (OWCP)

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*
Inner, Thomas E

2. HOME MAILING ADDRESS *(Number, street, city, state, zip code)*
2 South Chase Street
Baltimore, MD 21230

3. DATE AND HOUR OF INJURY *(Mo., day, year)*
3/1/83 3:15 ☐ AM ☑ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo. day, year)*
FROM 3/1/83 TO Continuing

5. WHAT HISTORY OF INJURY *(including disease caused by the employment)* DID EMPLOYEE GIVE YOU?
fell 3 feet on right side and lower ribs hit a metal pipe

6. WHAT ARE YOUR FINDINGS *(include results of X-rays, laboratory tests, etc.)*?
multiple rib fractures
pneumothorax

7. WHAT IS YOUR DIAGNOSIS?
right rib fracture - 6, 7, 8, 9 with lung puncture
pneumothorax

8. I BELIEVE THE CONDITION FOUND WAS ☐ /WAS NOT ☐ CAUSED OR MATERIALLY AGGRAVATED BY THE EMPLOYMENT ACTIVITIES DESCRIBED. MY MEDICAL RATIONALE IS ATTACHED.

9. DID INJURY REQUIRE HOSPITALIZATION? ☑ YES ☐ NO
NAME AND ADDRESS OF HOSPITAL
DATE OF ADMISSION *(Mo., day, year)* 3/1/83
DATE OF DISCHARGE *(Mo., day, year)* 3/10/83

10. IS ADDITIONAL HOSPITALIZATION REQUIRED?
☐ YES ☑ NO

11. SURGERY ☐ YES ☑ NO *(If yes, attach copy of report)*

12. DATE SURGERY PERFORMED *(Mo., day, year)*

13. WHAT *(Other)* TYPE OF TREATMENT DID YOU PROVIDE?

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?

15. DATE OF FIRST EXAMINATION *(Mo., day, year)*
3/1/83

16. DATES OF TREATMENT *(Mo., day, year)*
3/1 - 3/10 inpatient

17. DATE OF DISCHARGE FROM TREATMENT *(Mo., day, year)*
has not

18. PERIOD OF DISABILITY *(If termination date unknown, indicate)* *(Mo., day, year)*
TOTAL DISABILITY: FROM 3/1 TO unknown
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME *(Mo., day, year)*
LIGHT WORK unknown
REGULAR WORK

20. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO, IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK THAT COULD BE REASONABLY PERFORMED WITH THESE LIMITATIONS.

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.
next examination 3/17/83

23. TYPED OR PRINTED NAME AND SIGNATURE OF PHYSICIAN *(Include Professional Degree)*
Reginald E Parks

24. ADDRESS *(Number, street, city, state, zip code)*
Franklin Sq Hosp

25. DATE OF REPORT *(Mo., day, year)*
3/12/83

Form CA-20
Rev. June 1979

2. Select the statement below which describes the most critical piece of information needed prior to submission of the claim to OWCP:

   a. Address of hospital.

   b. Type of treatment provided.

   c. Anticipated permanent effects from the injury.

   d. Whether the current disability is a result of the injury as described by the claimant.

PERFORMANCE TEST
INNER CASE
TASK III

You have obtained a statement from the claimant and a statement from the supervisor. The hospital emergency room report and the hospital discharge report are also attached. Review them on pages 10 - 13. Then answer the question on page 14.

PERFORMANCE TEST
INNER CASE
TASK III

STATEMENT

1. Describe in detail exactly how the injury occurred (for example, if you fell, how you landed, etc. Also did you strike a pipe. If so, what pipe. Where was it?

   Answer: I was walking in front of #16 Park Heights Avenue getting ready to deliver mail there when I slipped on something - could have been a leaf. I fell forward onto the top of the fence post which struck me on the right side. The fence was low, only about 2 feet high.

2. Give the names of any persons who witnessed your injury.

   Answer: There were no witnesses around.

3. State the immediate effects of the injury and what you did immediately thereafter.

   Answer: I felt a sharp pain, but I thought I could finish my route, so I did even though it was painful to breathe. However, that evening I felt increased pain so I went to the hospital.

4. Was any other injury sustained, either on or off duty, between the time of injury and the time you first reported to (a) your supervisor (b) to a doctor? If so, describe.

   Answer: I sustained no other injury.

5. Describe exactly why you delayed in seeking medical attention for some three hours after the injury occurred.

   Answer: I thought that I could finish my route so I did.

Thomas E. Inner

PERFORMANCE TEST
INNER CASE
TASK III

STATEMENT

In response to your request for information concerning the 3/1/83 injury of Thomas E. Inner, please be advised of the following:

1) Mr. Inner did not report the injury to me on 3/1/83. He returned to the station at approximately 4:00 p.m., had a discussion with me about certified mail, and left. At no time did he mention an injury or appear to be in any discomfort. My first knowledge of the injury was a verbal conversation with Mr. Inner at 7:30 a.m. on 3/2/83.

2) At 3:15 p.m. Mr. Inner should have been at the address where the alleged injury occurred.

3) From the time of injury until his return to the station, Mr. Inner was delivering mail for approximately 45 minutes. During this period he walked approximately 2 1/2 blocks and climbed steps with a partially loaded mail satchel on his shoulder weighing approximately ten pounds. He drove his delivery vehicle back to the station approximately four miles.

If further information is necessary, do not hesitate to contact me.

John Doerr
Supervisor, Delivery

FRANKLIN HOSPITAL

ADMISSION NOTES

PATIENT: Thomas E. Inner
Date: 3-1-83
Admitted to: William B. Collins, M.D.

52 year old white male who while walking fell on his right rib cage feeling a sharp pain to area of contusion as well as some mild respiratory difficulty (shortness of breath). Came to ER complaining about pain but not respiratory difficulty anymore.

PMH unremarkable.

NKA - no medications.

PE - There is a very tender area to right lower rib cage which increases to MOV and to deep breathing. There is no shortness of breath at this time.

2 AUC: - diffused spreading in right lung field.

NOTE: Echymotic area 5 - 6 centimeters diameter. #6 painful area. C/U stable, no murmurs, no PVCs. No oradexic pulse. Pupils PERRLA. Neck: no seen rejurgitation. No tracheal deviation. ABD: flat, soft, portends to polp, no masses. Neurologic exam: WNL. Impression: fractured ribs 6 - 10, right 15 - 20% neumothorax.

FRANKLIN HOSPITAL

DISCHARGE SUMMARY

PATIENT: Thomas E. Inner
Date: 3-7-83
Admitted to: William B. Collins, M.D.

History of Present Illness:
This 52 year old white male fell and struck his right chest on the day of admission and sustained fractures of his 6th, 7th, 8th, 9th, and possibly the 10th ribs on the right side within approximately 10 - 15% pneumothorax. Tube thoracostomy done in ER which brought prompt re-expansion to the lung. His air leak had sealed promptly.

Hospital Course:
He was admitted for observation. His chest tube was removed on 3-3-83. On 3-4-83 his chest X-ray revealed the lung to be completely expanded. He was discharged to be followed in my office.

Final Diagnosis:
Traumatic fracture right 6, 7, 8, 9, and possibly 10th ribs. Operation 3-3-83 tube thoracostomy. Ongoing medications - none.

Disposition:
Return to my office in 3 days for suture removal. Diet - regular. Activity - light

William B. Collins, M. D.

3. On the Answer Sheet mark the letter of the item listed below that best describes what you would do to controvert the claim:

   a. You would do nothing else - you have sufficient evidence to successfully controvert this case.

   b. You would gather additional medical evidence on whether the claimant could have performed his job after his injury.

   c. You would ask the supervisor whether there were other witnesses at the station at 4 p.m. who could provide information on Mr. Inner's condition at the time.

PERFORMANCE TEST
HEWITT CASE
TASK I

You have been asked to review Mr. Hewitt's claim for a recurrence of a leg injury. Review the original CA-1 and the CA-2a (Recurrence) which follow on pages 16 - 19. Then answer the questions on page 20.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
Hewitt, John Raymond	4-12-48		239-06-4958

5. Employee's Home Mailing Address (No., street, city, state, zip code): 31 Rockbridge Ave. Chesapeake, Va. 23321

6. Home Telephone Area Code: Number: (804) 498-0241

7. Name and Address of Employing Agency: Norfolk Naval Shipyard Portsmouth, Va.

8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine): Stairs, Bldg. 163

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
11 | 24 | 83 ☑ AM ☐ PM 10:00	11 | 26 | 83	Wife/Husband ☐ Children Under 18 Years Old ☐	Shiptitter

13. Cause of Injury (Describe how and why the injury occurred): Fell down steps of Bldg. 163.

14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.): Broke right leg

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☐ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

John R. Hewitt
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury): I saw Hewitt fall down the steps of Bldg. 163 on November 24, 1983 at about 10:00 a.m. I called the Dispensary ambulance for him. I heard later he broke his leg

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)
Robert Bayle	3021 South St, Ports.	11 | 26 | 83

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency: NAVY

22. Bureau or Office: DON

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*: Portsmouth, Va. 23709

24. Regular Work Day — Begins 7:20 ☒ AM ☐ PM — Ends 4:00 ☐ AM ☒ PM

25. Number of Hours Worked Per Day: 8

26. Circle Days Paid Per Week: S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*: 10:00 11/24/83 ☒ AM ☐ PM

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*: 11/24/83

29. Date and Hour Stopped Work *(mo., day, year)*: 11/24/83

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*:

31. 45 Day Period Begins *(mo., day, year)*: 11/25/83

32. Pay Rate When Employee Stopped Work: $10.50 per hr.

33. Date and Hour Employee Returned to Work *(mo., day, year)* ☐ AM ☐ PM

34. Name of Supervisor at Time of Injury: Nelson

35. Was Employee in Performance of Duty At The Time of Injury? ☒ Yes, ☐ No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?

☐ Yes ☒ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☒ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*: 11/24/83

39. Name and Address of Physician First Providing Medical Care: DR. M.C Richardson Dispensary

40. Do Medical Reports Show Employee is Disabled For Work? ☒ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? ☒ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☒ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated . Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions

☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder

☒ Medical Expense Incurred or Expected. Forward this Form to OWCP

☒ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor: James Nelson

46. Title and Office Phone Number: Shipfit Foreman

47. Date *(mo., day, year)*: 11/26/83

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

NOTICE OF EMPLOYEE'S RECURRENCE OF DISABILITY AND CLAIM FOR PAY/COMPENSATION

IMPORTANT: Before completing this form please read carefully the instructions.

PART A – EMPLOYER

1. NAME OF INJURED EMPLOYEE *(last, first, middle)*	2. SOCIAL SECURITY NUMBER	3. OWCP file number for original injury *(if known)*
Hewitt, John Raymond	239-06-4928	A25-30690

4. HOME MAILING ADDRESS *(include zip code)*	5. HOME TELEPHONE
31 Rockbridge Ave., Ches. Va. 23321	Area Code 804 Number 498-0241

6. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of original injury *(number, street, city, state, zip code)*	7. NAME AND ADDRESS OF EMPLOYING ESTABLISHMENT at time of recurrence, if other than 6.
Norfolk Naval Shipyard Portsmouth, Va.	was at home

8. DATE AND HOUR of original injury *(mo., day, year)*	9. DATE AND HOUR of recurrence *(mo., day, year)*	10. DATE AND HOUR stopped work following recurrence *(mo., day, year)*	11. DATE AND HOUR pay stopped following recurrence *(mo., day, year)*
11/24/83 ☑ a.m. ☐ p.m.	4/4/84 ☐ a.m. ☑ p.m.	4/5/84 ☐ a.m. ☐ p.m.	☐ a.m. ☐ p.m.

12. PAY RATE IN EFFECT ON:	a. Base pay	b. Subsistence	c. Quarters	d. Other pay
A. Date of Recurrence	$10.50 per hr.	$ per	$ per	$ per
B. Date Stopped Work Following Recurrence	$10.51 per hr.	$ per	$ per	$ per

13. Show work week at time pay stopped, if other than Monday thru Friday	14. DATE AND HOUR returned to work, following recurrence *(mo., day, year)*	15. At time of recurrence did official superior authorize medical treatment?
S M T W T F S	4/12/84 ☑ a.m. ☐ p.m.	☐ YES ☐ NO Went to Emergency Room

16. DATE employee first received medical treatment following recurrence *(mo., day, year)*	17. NAME AND ADDRESS of physician treating employee following recurrence
4/4/84	DR. Blaine Shaw, General Hospital

18. After returning to work following the original injury, was the employee handicapped or in any way limited in performing his/her usual duties? ☐ YES ☐ NO *(If yes, explain)*

Employee RTD on 12/28/83, on light duty. On 3/28/84 he was placed on full duty, except for one restriction, no repeated bending or stooping. On 3/28/84 he was placed on full duty.

19. Describe the circumstances of the recurrence of disability as reported by the employee. If the condition gradually worsened over a period of time, describe the progress of the condition from the time employee returned to work up to the date of recurrence.

Employee States that on April 4, 1984, he was sitting on his back porch at home. As he got up to go into the den, he tripped and his weak right leg gave way from under him. Tore ligament in right leg.

20. Signature of official superior *(at time of recurrence)*	21. Title	22. Official superior's work phone number	23. Date *(mo., day, year)*
—	—		

Form CA-2a
Rev. July 1976

PART B – CONTINUATION OF PAY

24. Inclusive dates that employee's regular pay continued during this period of recurrence. Do not include period of sick or annual leave. *(mo., day, year)*

From: Through:

25. Show gross dollar amount of regular pay which employee received during this period of recurrence.

$

26. If pay changed during the period employee was receiving continuation of pay, for this recurrence, show date of change *(mo., day, yr.)*.

27. If pay rate changed during the period employee was receiving continuation of pay, give new rate.

a. Base Pay	b. Subsistence	c. Quarters	d. Other *(specify)*

PART C – EMPLOYEE

28. Complete this item if you worked during the period shown in item 29(b) or 29(c).

a. Dates & Hours Worked	b. Pay Rate *(per hour, day or week)*	c. Total Amount Earned	d. Type Work Performed	e. Name & Address of Employer

29. I certify that the recurrence claimed on date in item 9 was due to the injury shown in item 8 and I hereby claim medical treatment, if needed, and the following as checked below, while disabled for work:

☐ a. Sick and/or annual leave

Period: From: Through:

☑ b. Continuation of regular pay not to exceed 45 days, which will include days taken during the original injury and prior recurrence(s), and compensation for wage loss if disability for work continues beyond 45 days. *(If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).*

Period: From: 4/5/84 Through: 4/12/84

☐ c. Continuing compensation on account of occupational disease.

Period: From: Through:

30. Signature of Employee or Person Acting on his/her Behalf

John R. Dennett

31. Date *(Month, day, year)*

4/5/84

PERFORMANCE TEST
HEWITT CASE
TASK I

4. Which statement below best describes the major issue(s) to be resolved in this case? Mark the letter of the best answer on your Answer Sheet.

   a. Whether or not Mr. Hewitt is entitled to COP

   b. Given the length of time for which Mr. Hewitt has been exposed to job conditions which may exacerbate his leg injury, it may now be an occupational disease case

   c. Whether his injury at home is related to his job-related injury

   d. Whether Mr. Hewitt's injury at home is the result of a premature return to full duty which violated his work restrictions

5. Indicate which of the sources listed below is most likely to provide the information you need to determine whether Mr. Hewitt's injury at home is related to his previous on-the-job injury. Mark the letter of the one best answer on your Answer Sheet.

   a. Interview Mr. Hewitt's supervisor, asking whether there have been instances on the job when Mr. Hewitt complained about his leg giving way.

   b. Identify and interview witnesses of the injury other than family members, if any.

   c. Interview the claimant for a description of how the injury occurred.

PERFORMANCE TEST
HEWITT CASE
TASK III

Read the statement from Mr. Hewitt below:

CLAIMANT'S STATEMENT

On 4/4/84 I was sitting in a swing on my back porch. After a while I decided to go into the den. When I got up I did not see my son's toy truck on the floor. I accidentally stepped on the truck with my left foot. It rolled from under me and caused me to trip. I fell on the floor landing on my left side.

I believe that I would have been able to break my fall if my right leg had not been weakened by my work injury. Because of the work injury my weak leg gave way causing my fall.

John R. Hewitt

---

6. On your Answer Sheet mark the letter of the item(s) listed below that describe the grounds on which you would controvert this case:

   a. Current disability is not a result of a job-related injury

   b. Not timely filed

   c. Failure to establish fact of injury

   d. Injury did not occur during performance of duty.

7. Do you have sufficient evidence to controvert this claim?

   a. Yes

   b. No

8. Would you pay COP?

   a. Yes

   b. No

   c. Since you can't controvert, the question is irrelevant.

PERFORMANCE TEST
LONG CASE

Review the following CA-1 and CA-17 for Raymond T. Long on pages 24 - 27. Then answer the questions on page 28.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee *(Last, first, middle)*	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
Long. Raymond T	1-1-30		016-52-1116

5. Employee's Home Mailing Address *(No., street, city, state, zip code)*	6. Home Telephone
211 South Green St Balto Md 21206	Area Code: 301 Number: 462-1901

7. Name and Address of Employing Agency	8. Place Where Injury Occurred *(e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)*
US Dept of Agriculture Raspeburg Station Balto Md 21206	Parking lot - Raspeburg Station

9. Date and Hour of Injury *(mo., day, year)*	10. Date of This Notice *(mo., day, year)*	11. Dependents	12. Employee's Occupation
12/27/83 2:45 ☐ AM ☑ PM	12/28/83	Wife/Husband ☑ Children Under 18 Years Old ☑	Computer Spec

13. Cause of Injury *(Describe how and why the injury occurred)*	14. Nature of Injury *(Identify the part of the body injured, e.g., fractured left leg, etc.)*
Twisted left Knee - no cause - just started to walk away from jeep - Knee gave way	Left Knee

15. If This Notice and Claim Was Not Filed With The Employing Agency Within Two Working Days After The Injury, Explain The Reason For The Delay.

16. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Raymond T. Long
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness *(Describe what you saw, heard or know about this injury)*

None

18. Witness' Signature	19. Witness' Address	20. Date Signed *(mo., day, year)*

Form CA-1
Rev. Sept. 1978

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
USDept of Agriculture	Raspeburg Station #559000

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
Rm 217 M.P.I
900 E Fayette St Balto Md 21233-9408 922-4977

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 6:00 ☑AM ☐PM Ends 2:30 ☐AM ☑PM	8	S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
12/27/83 2:45 ☐AM ☑PM	12/28/83 6:00	12/27/83 2:30	N/A

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor at Time of Injury
12/28/83	$ 24.042 per _____	12/30/83 6:00 ☑AM ☐PM	R. Simmons

35. Was Employee in Performance of Duty At The Time of Injury? ☑Yes, ☐No. If No, furnish a detailed explanation or attach copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for the Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee is Disabled For Work?
12/28/83	Carroll County General Hospital Old Court Rd. Randallstown, Md	☑Yes ☐No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑Yes ☐No. If No, Furnish A Detailed Explanation.
As stated by the employee

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☐ No. If Yes, Give Full Explanation for Basis of Controversion (See Item 6 of Instruction Sheet), and, if applicable, the date pay was terminated . Attach Additional Sheets If More Space Is Needed.

43. Filing Instructions
☐ No Lost Time and No Medical Expense. Place this Form in Employee's Official Personnel Folder
☑ Medical Expense Incurred or Expected. Forward this Form to OWCP
☑ Lost Time Covered by Leave, LWOP, or COP. Forward this Form to OWCP

44. All Information requested on this Form has been furnished. If Not, it will be submitted by _____ *(Fill in Date)*

45. Signature of Supervisor	46. Title and Office Phone Number	47. Date *(mo., day, year)*
P Simmons	Super-Admin. Services 922-4016	12/31/83

OMB NO. 1215-0103 —Exp. 8-30-84

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Carroll County General Hospital Inc
Old Court Rd
Randallstown, Md

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Long Raymond T	12/27/83	Computer Spec	016-52-1110

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

Knee gave way- twisted left Knee

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT 3 hours office COLD 5 hours street NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			} 5 hours
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS	0		
PULLING/PUSHING, CARRYING			5 hours
REACHING OR WORKING ABOVE SHOULDER		3	
WALKING (HOURS)			5
STANDING (HOURS)		3	
SITTING (HOURS)	0		
STOOPING (HOURS)	1		
KNEELING (HOURS)	0		
REPEATED BENDING (HOURS)	1		
CLIMBING (HOURS)	1		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	1		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

U.S. Dept. of Agriculture
900 E. Fayette St, Rm 217
Balto Md. 21233-9408

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☑ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

Soft tissue injury left knee - bursitis

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*

TOTAL DISABILITY FROM 12/28 TO 12/29

PARTIAL DISABILITY FROM N/A TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*

LIGHT WORK ☐ none

REGULAR WORK ☑ 12/30/83

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☑ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

12/28/83

16. DIAGNOSIS OF CONDITION DUE TO INJURY

Soft tissue injury left knee - bursitis

17. DATE OF EXAMINATION 12/28/83

18. DATES OF FURTHER APPOINTMENTS, IF ANY

none

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

A. N. Woodward

20. PROFESSIONAL DEGREE

M.D.

21. DATE *(Mo., day, year)*

12/28/83

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

9. On your Answer Sheet mark the letter of the one choice below which best describes the course of action you should take:

   a. You should ask for a more complete medical report indicating the relationship between the alleged injury and the work disability.

   b. The claim should be controverted on the grounds that the current disability is not a result of the job-related injury (knee gave way) but of a pre-existing condition (bursitis).

   c. You should ask for a detailed statement from the employee, describing how the injury occurred (e.g., how did he "twist" his knee etc.).

   d. You should interview the supervisor to establish that the claimant was actually in the performance of duty (parking lot).

   e. You should do <u>both</u> a and c.

   f. You should forward the claim as it is to OWCP.

PERFORMANCE TEST
CHARGEBACK A

Use the following chargeback billing list (A) to do this task. Note that the full compensation range for this agency is $12,000 to $17,000. For this task assume that you are reviewing the chargeback list on August 15, 1983.

10. Select the claimants whose files you want to review for possible payment errors. On the Answer Sheet mark the letter in front of each name that you select.

11. Select claimants whose files you want to review for adequate medical justification. On the Answer Sheet mark the letter in front of each name that you select.

"A"

DV1PCB40 E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS

REPORT DATE: 07/31/83 DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1,1982-JUNE 30, 1983

DEPARTMENT: DEPARTMENT OF THE NAVY AGENCY: NAVAL SEA SYSTEMS COMMANI

ACCOUNT: NORFOLK NAVAL SHIPYARD, PORTSMOUTH,VA ACCOUNT NUMBER: 6603

	EMPLOYEE NAME			DATE OF INJURY	PAYMENTS ---MEDICAL--- NO.	AMOUNT	---COMPENSATION NO.	AMOUNT	ROLL	ADJ
a.	POWELL	JOHNNIE	H	01/06/61			14	6,641.42	P	
b.	NOBLE	HENRY	R	08/04/61	3	74.00				
c.	HARRIS	EDDIE	C	07/04/62			14	13,273.94	D	
d.	SPRUILL	WILSON	B	12/21/62			14	7,260.07	P	
e.	DENNIS'	RUSSELL	A	08/03/64			13	12,266.93	D	
f.	BAILEY	JOHN	P	06/13/65	5	9,451.44	14	14,676.14	P	
g.	BAZEMORE	GEORGE	W	02/21/66			13	11,962.93	D	
h.	JACKSON	AMOS		01/05/66	1	165.00	14	12,859.21	P	
i.	MCCUTCHEN	MANNING		11/01/66			13	10,464.40	D	
j.	PETROSKEY	JOHN	S	09/19/66	11	1,729.30	16	3,478.52	P	
k.	SIMMONS	CHARLES	N	09/15/67			11	11,635.00	D	
l.	SCOTT	JOHN	R	08/28/67			15	10,905.41	D	M
m.	SHEFFIELD	CHARLES	E	10/31/67			14	14,594.32	P	
n.	EARLY	JIMMY	M	11/21/67			2	165.50-	S	
o.	TAYLOR	JOHNNIE	A	04/30/68			2	2,204.67	P	M
p.	CARROLL	EDWARD	H	11/13/81	12	6,635.00	14	16,987.07	P	
q.	CONNER	IRA	S	09/20/68	1	25.00				
r.	CLARK	EARNESTINE	C	03/14/69	11	2,767.92	2	5,219.05	S	
s.	KNICK	EARL	B	12/07/67			13	11,086.93	D	
t.	MEADE	GARLAND		04/16/69	6	191.72	14	9,021.17	P	
u.	PERDUE	PAUL	D	04/10/69	3	88.20	19	29,210.09	P	
v.	BRADLEY	ARTHUR	L	07/09/69	9	291.47	14	13,832.67	P	
w.	FALOS	CARL	R	06/19/70	11	12,255.60	14	10,924.75	P	
x.	NICHOLS	MASON	E	10/19/67			14	13,451.85	P	
y.	HARCUM	GEORGE	E	07/02/70	3	373.66	14	14,096.50	P	
z.	MASTON	PATRICIA	L	07/09/70			14	9,363.00	P	
a.a	SAWYER	WILLIAM	J	03/04/68			12	13,224.00	D	
bb	WITHAM	WARREN	B	05/17/61	1	20.00	14	14,923.14	P	
cc.	KNOTTS	K		06/23/76	1	35.00	1	1,855.20	S	
dd.	WOLFENDALE	KEVIN	H	02/18/77	23	1,473.92				

PERFORMANCE TEST
CHARGEBACK B

Use the following Chargeback Billing List (B) to do this task. Note that the full compensation range for this agency is $12,000 to $17,000. For this task assume you are reviewing the chargeback list on October 16, 1983.

12. Select the claimants whose files you want to review for possible payment errors. On the Answer Sheet mark the letter in front of each name that you select.

13. Select claimants whose files you want to review for adequate medical justification. On the Answer Sheet mark the letter in front of each name that you select.

"B"

DV1PCB40 E.S.A. OFFICE OF WORKERS COMPENSATION PROGRAMS
REPORT DATE: 07/31/83 DETAILED CHARGEBACK BILLING LIST FOR PERIOD: JULY 1,1982-JUNE 30, 1983

DEPARTMENT: DEPARTMENT OF THE NAVY AGENCY: NAVAL SEA SYSTEMS COMMAND-

ACCOUNT: NORFOLK NAVAL SHIPYARD, PORTSMOUTH,VA ACCOUNT NUMBER: 6603

	EMPLOYEE NAME			DATE OF INJURY	PAYMENTS ---MEDICAL--- NO.	AMOUNT	---COMPENSATION NO.	AMOUNT	ROLL	A D J
a.	BONNEY	REGINALD	L	04/26/71	1	125.00	12	608.64	P	
b.	URQUHART	LUCILLE	V	06/21/70	3	420.00	14	9,571.00	P	
c.	CREECH	MARSHALL	H	10/12/71	4	565.00	14	16,779.07	P	
d.	MOONE	LEE	A	10/15/71			13	780.00	P	
e.	WATFORD	EDWARD	B	10/29/71			1	72.00-	P	
f.	COX	CLYDE	E	12/07/71	2	1,055.10	3	2,244.63	P	*
g.	WALTON	EDGAR	B	09/08/71			24	9,041.34	D	*
h.	RENN	ANDREW	G	09/30/71			14	14,689.14	P	
i.	LEE	ELIJAH		01/14/72	1	20.00				
j.	DAVIS	REGINALD	W	02/04/72			1	50.00-	P	
k.	DIGGS	WILLIE	O	02/28/72			14	1,419.28	P	
l.	GRANT	JOHNNIE	L	03/10/71	1	345.00	14	14,399.32	P	
m.	ROUNTREE	ROLAND	T	11/16/71			1	100.00-	S	
n.	CAHOON	THOMAS	L	04/08/72	3	170.00	14	13,032.03	P	
o.	WRIGHT	ED	B	04/24/72			5	125.00-	S	
p.	VAUGHAN	THOMAS	W	06/05/72	1	20.00				
q.	PAYNE	SHELTON	M	05/11/72	18	970.00	14	15,961.60	P	
r.	GLOVER	GRACE	H	05/16/72	20	615.00	14	11,426.92	P	
s.	REID	ALICE	J	08/15/68	5	180.00	13	10,591.10	P	
t.	SMITH	LESLIE		02/29/72	2	576.00				
u.	HOWARD	ALFRED	R	11/07/72	7	1,372.80				
v.	ROSS	CHARLES	L	12/08/72			18	15,366.33	S	
w.	BLYTHE	LELAND	J	01/08/82	20	8,607.63	14	18,341.35	P	
x.	WRAY	CLAUDE	S	02/26/73			14	14,715.14	P	
y.	NELSON	LEVIN	F	03/13/73			12	11,244.00	D	
z.	DUKE	JOHNNIE	F	10/01/76	12	6,688.90	14	13,702.67	P	
aa.	LUFSEY	PERCY	E	01/31/73	1	35.00	3	750.00-	P	
bb.	HEDGEPETH	SAMUEL	W	05/24/73			2	60.00-	S	
cc.	ABBOTT	JOHN	F	05/11/73	1	75.00	14	21,997.39	P	

PERFORMANCE TEST
SMITH CASE
TASK I

You have identified several cases which are on the periodic roll from the chargeback list and are reviewing updated files on them.

The case file of Mr. Paul Smith indicates that he was injured on 2/14/80 while working at the Norfolk Naval Shipyard. He has not worked since his injury. He is still on his agency's rolls. Review the attached information from Mr. Smith's case file on pages 34 - 44. Then answer the question on page 45.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3.	4. Social Security Number
Smith, Paul E.	10/10/48	☑ Male ☐ Female	505-10-2168

5. Employee's Home Mailing Address (No., street, city, state, zip code)
25 Fairway Drive
Portsmouth, VA 23701

6. Home Telephone
Area Code: 804
Number: 488-1245

7. Name and Address of Employing Agency
Norfolk Naval Shipyard
Industrial Relation Office
Portsmouth, Va 23709

8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
USS Nimitz
O11 Level

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
2/14/80 ☐ AM ☑ PM 3:00	2/14/80	Wife/Husband ☑ Children Under 18 Years Old ☑	Welder

13. Cause of Injury (Describe how and why the injury occurred)
I was welding a 15" pipe when it came loose & fell on my right foot. Pipe weighed about a 100lbs.

14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
Rt. Toe & Foot

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Paul Smith
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)
N/A

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency
Navy

22. Bureau or Office
Norfolk Naval Shipyard

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
Norfolk Naval Shipyard
Industrial Relations Office
Portsmouth, Va 23709

24. Regular Work Day
Begins 7:30 ☑ AM ☐ PM
Ends 4:00 ☐ AM ☑ PM

25. Number of Hours Worked Per Day
8

26. Circle Days Paid Per Week
S (M) (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*
2/14/80 ☐ AM ☑ PM 3:00

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*
2/14/80

29. Date and Hour Stopped Work *(mo., day, year)*
2/14/80

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
—

31. 45 Day Period Begins *(mo., day, year)*
2/15/80

32. Pay Rate When Employee Stopped Work
$8.00 per hour

33. Date and Hour Employee Returned to Work *(mo., day, year)*
☐ AM ☐ PM
8:11 am

34. Name of Supervisor At Time of Injury
mr. Christian

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*
2/14/80

39. Name and Address of Physician First Providing Medical Care
Dr. A.A. Kirk
3636 High ST
Portsmouth, Va

40. Do Medical Reports Show Employee Is Disabled For Work?
☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor
Billy Talley

44. Title and Office Phone Number
Head, Employee Services
(804 396-7886)

45. Date *(mo., day, year)*
2/16/80
DW

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A -- AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Dr. A.A. Kirk
3636 High Street
Portsmouth, Va

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Smith, Paul E.	2/14/80	Welder

5. DESCRIPTION OF INJURY OR DISEASE

"I was welding a 15" pipe when it came loose & Fell on my right foot/toe."

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Billy Gallup	Head, Engayee Services Div
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
(804) 396-5808	2/14/80

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency NAVY Bureau or Office Norfolk Naval Shipyard Local Address (Including Zip Code) Portsmouth, Va 23709

FORM CA-16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle)
Smith, Paul E

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?
Pipe fell on Rt Foot

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)
☐ Yes ☒ No

17. WHAT ARE YOUR FINDINGS (include results of x-rays, laboratory tests, etc.)?
Traumatic arthritis metatarsophalangeal joint rt great Toe

18. WHAT IS YOUR DIAGNOSIS?
Traumatic Arthritis Metatarsophalangeal Joint Rt great Toe

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)
☒ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION? ☒ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED? Unknown
☐ Yes ☐ No

22. SURGERY (If any, describe type)
Excision of Neuroma rt. great Toe

23. DATE SURGERY PERFORMED (mo., day, year) 3|12|80

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
—

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
Unknown

26. DATE OF FIRST EXAMINATION (mo., day, year)
2|14|80

27. DATE(S) OF TREATMENT (mo., day, year)
2|14|80, 3|5|80,

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)
—

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM 2|14|80 TO present
PARTIAL DISABILITY: FROM TO

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK
REGULAR WORK Undetermined

31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☒ NO IF YES, FURNISH DATE ADVISED (month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.
—

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.

34. DO YOU SPECIALIZE? ☒ Yes ☐ No (If yes, state specialty) Orthopedics

35. SIGNATURE OF PHYSICIAN
C. C. Kirk

36. ADDRESS (Number, street, city, state, zip code)
3636 High ST
Portsmouth, Va

37. PHYSICIAN'S SOCIAL SECURITY NUMBER
222-22-2222

38. DATE OF REPORT (mo., day, year)
3/15/80

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price Cost	Unit price Per	Amount $	Amount ¢
	TOTAL					

U.S. GOVERNMENT PRINTING OFFICE : 1979 O—305-889

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION Office of Workers' Compensation Programs (OWCP)	CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*	2. Social Security Number	3. OWCP File Number *(If known)*
Smith, Paul E	505-10-2168	

4. Is Claim Being Made For Wage Loss?	5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body?
☑ Yes ☐ No	☐ Yes ☑ No

6. Period Compensation Is Claimed As A Result Of Wage Loss *(Mo., day, year)*	7. Has Any Pay Been Received For The Period Shown In Item 6?
From: 4/1/80 Through: Continuing	☐ Yes ☑ No If Yes, State Full Amount And Inclusive Dates For Such Period *(Mo., day, year)* $____ From: ____ Through: ____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☑ No If Yes, Give Name And Address Of Such Party Or Insurance Carrier	9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States? ☐ Yes ☑ No If Yes, Furnish →	a. Service Number	b. Branch Of Service	c. Period Of Service *(Mo. day, year)* From: ____ Through: ____

11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? ☐ Yes ☑ No If Yes, Furnish →	a. Claim Number	b. Address of VA Office Where Claim Is Filed	c. Nature Of Disability And Monthly Payment

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? ☐ Yes ☑ No If Yes, Furnish →	a. Claim Number	b. Date Annuity Began *(Mo., day, year)*	c. Amount of Monthly Payment
			$____

13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? *(Yes/No)*	Mailing Address, If Different From Your Own
Debra A.	Spouse	6/1/49	Yes	—

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

15. Employee's Signature	16. Employee's Home Mailing Address *(Include Zip Code)*	17. Date *(Mo., day, year)*
Paul E. Smith	25 Fairway Drive Portsmouth, Va 23701	4/1/80

Form CA-7
Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office *(Number, street, city, state, zip code)*
Norfolk Naval Shipyard, Employee Services Div, Portsmouth Va

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
Date of Injury →	$3.00 per hour	$ per	$ per	$ per
Date Employee Stopped Work →	$3.00 per hour	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount
Type N/A $ _____ per _____

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?
☑ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?
☑ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service
2 yrs

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*
—	—	—

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes
$3.00 per hour

27. Inclusive Dates Regular Pay Continued During Period of Disability. Do Not Include Periods of Sick or Annual Leave
From: 2/15/80 Through: 3/30/80

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$ _____

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*	a. Base Pay	b Subsistence	c. Quarters	d. Other *(Specify)*
	$ per	$ per	$ per	$ per

PART D – COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*
4/1/80 ☐ AM ☐ PM

31. Period For Which Compensation Is Claimed
From: 4/1/80 Through: Continuing

32. Deductions:
a. Was Employee Enrolled On Date Pay Stopped? Health Benefits ☐ Yes ☑ No; Optional Insurance ☐ Yes ☑ No
b. If Yes, Furnish Code Number. ☐☐☐ ☐☐☐
c. If Yes, Give Date Through Which Deductions Were Last Made.

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*
Still Out ☐ AM ☐ PM

34. Pay Rate At Time Returned To Work
$ _____ per _____

35. Show Work Week On Return To Work If Other Than Monday Through Friday
S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F – CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*
Billy Gallup	Head, Employee Services Div (804 396-5808)	4/1/80

CA-7
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION Office of Workers' Compensation Programs	ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE (Last, first, middle): Smith, Paul E

2. HOME MAILING ADDRESS (Number, Street, City, State, Zip Code): 25 Fair Wall Dr. Portsmouth, Va

3. DATE AND HOUR OF INJURY (Mo., Day, Year): 2/14/80 3:00 ☐ AM ☑ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., Day, Year): FROM 4/1/80 TO Continuing

5. WHAT HISTORY OF INJURY (Including disease caused by the employment) DID EMPLOYEE GIVE YOU?
Pipe fell on foot

6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
Traumatic arthritis Metatarsophalangeal joint, right great toe

7. WHAT IS YOUR DIAGNOSIS?
Same as above

8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts)
☑ YES ☐ NO

DID INJURY REQUIRE HOSPITALIZATION? ☑ YES ☐ NO
IF YES, DATE OF ADMISSION (Mo., Day, Year)
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? Unknown ☐ YES ☐ NO

11. OPERATIONS (If any, describe type)
Excision of neuroma rt great toe

12. DATE OPERATIONS PERFORMED (Mo., Day, Year): 3/12/80

13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
Unknown

15. DATE OF FIRST EXAMINATION (Mo., Day, Year): 2/14/80

16. DATES OF TREATMENT (Mo., Day, Year)

17. DATE OF DISCHARGE FROM TREATMENT (Mo., Day, Year)

18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year)
TOTAL DISABILITY: FROM 2/14/80 TO Continuing
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME (Mo., Day, Year)
LIGHT WORK
REGULAR WORK

20. ADVISE IF EMPLOYEE IS ABLE TO RESUME WORK. ☐ YES ☑ NO IF YES, FURNISH DATE ADVISED.

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.
Prognosis Guarded

23. SIGNATURE OF PHYSICIAN: R. C. Kirk

24. ADDRESS (Number, Street, City, State, Zip Code): 3636 High Street Portsmouth, Va

25. DATE OF REPORT (Mo., Day, Year): 3/28/80

CA-20
(REV. AUG. 1976)

U.S. DEPARTMENT OF LABOR EMPLOYMENT STANDARDS ADMINISTRATION OFFICE OF WORKERS' COMPENSATION PROGRAMS	CLAIM FOR CONTINUING COMPENSATION ON ACCOUNT OF DISABILITY

FOR INSTRUCTIONS SEE REVERSE SIDE

STATEMENT OF INJURED EMPLOYEE

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*: Smith, Paul E

2. OWCP FILE NUMBER, IF KNOWN:

3. HOME MAILING ADDRESS *(Include zip code)*: 25 Fairway Dr. Portsmouth, Va 23701

4. SOCIAL SECURITY NUMBER: 505-10-2168

5. DATE AND HOUR OF INJURY *(Mo., day, year)*: 2/14/80 — 3:00 ☐ AM ☒ PM

6. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)*: FROM: 5/1/80 THROUGH: 5/31/80

7. HAVE YOU RECEIVED ANY LEAVE PAY DURING THE PERIOD SHOWN IN ITEM 6.?
☐ YES ☒ NO IF YES, COMPLETE ITEM 8.

8. AMOUNT RECEIVED $ _____
DATES COVERED BY LEAVE PAY
FROM: THROUGH:

9. COMPLETE THIS ITEM IF YOU WORKED DURING THE PERIOD SHOWN IN ITEM 6.

a. DATES & HOURS WORKED	b. PAY RATE (per hour, day or week)	c. TOTAL AMOUNT EARNED	d. TYPE WORK PERFORMED	e. NAME & ADDRESS OF EMPLOYER
		N/A		

10. IF YOU HAVE APPLIED FOR EMPLOYMENT WITH THE U.S. TRAINING AND EMPLOYMENT SERVICE GIVE THE FOLLOWING:
REGISTRATION NO. DATE OF REGISTRATION: N/A OFFICE ADDRESS

11. IF YOU WERE ONLY PARTIALLY DISABLED AND DID NOT WORK, STATE REASON FOR NOT WORKING.
N/A

12. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED VA BENEFITS BASED ON MILITARY SERVICE FOR THE UNITED STATES, GIVE THE FOLLOWING:
CLAIM NO. NATURE OF DISABILITY AND MONTHLY PAYMENT: N/A NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

13. IF, SINCE FILING YOUR INITIAL CLAIM FOR COMPENSATION, YOU HAVE APPLIED FOR OR RECEIVED AN ANNUITY UNDER THE CIVIL SERVICE RETIREMENT ACT OR OTHER FEDERAL RETIREMENT OR DISABILITY LAW, GIVE THE FOLLOWING:
CLAIM NO. AMOUNT OF MONTHLY PAYMENT: N/A NAME AND ADDRESS OF OFFICE WHERE CLAIM IS FILED

14. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF: Paul E. Smith

15. DATE *(Mo., day, year)*: 5/1/80

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price $5.35 per 100
Stock Number 029-016-00022-4

STATEMENT OF OFFICIAL SUPERIOR

16. IF EMPLOYEE HAS RETURNED TO WORK, SHOW DATE AND HOUR *(Mo., day, year)* ☐ AM ☐ PM

17. SHOW EMPLOYEE'S WORK WEEK ON RETURN TO DUTY, IF OTHER THAN MONDAY THRU FRIDAY

S	M	T	W	T	F	S

18. HAS EMPLOYEE RECEIVED ANY PAY FOR WORK, LEAVE, SUBSISTENCE, QUARTERS OR OTHER REMUNERATION FROM YOUR AGENCY DURING THE PERIOD SHOWN IN ITEM 6 ON THE REVERSE SIDE?

☐ YES ☐ NO

19. IF ANSWER TO ITEM 18. IS YES, SHOW:

AMOUNT: $

TYPE OF PAYMENT:

PERIOD: FROM: _____ THROUGH: _____

20. IF THERE HAS BEEN ANY CHANGE IN EMPLOYEE'S HEALTH BENEFIT ENROLLMENT AND/OR OPTIONAL INSURANCE SINCE PREVIOUS CLAIM FOR COMPENSATION WAS SUBMITTED, PLEASE EXPLAIN. *(i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)*

21. REMARKS

22. SIGNATURE OF OFFICIAL SUPERIOR	23. TITLE	24. DATE *(Mo., day, year)*
Becky Stallings	Head, Employee Ser. Div	5/2/80

INSTRUCTIONS FOR INJURED EMPLOYEE

a. Items 1. through 15. on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by the OWCP. A copy of the form will be enclosed with each compensation check. Additional copies may be obtained from the OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $2,000, or imprisonment for not more than one year, or both.

INSTRUCTIONS FOR OFFICIAL SUPERIOR

a. The official superior must complete items 16. through 24. and forward the form to the appropriate OWCP office.

b. The official superior must also complete items 1. through 6. on Form CA-20a before sending that form to the attending physician. It will also be necessary for the official superior to show in item 3. on the reverse of the Form CA-20a, the address of the OWCP office to which the physician should send the completed form.

If additional space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

NOTE: DELAY IN SUBMITTING THIS FORM PROPERLY COMPLETED, OR WITHOUT SUPPORTING MEDICAL EVIDENCE, WILL DELAY PAYMENT OF COMPENSATION.

Form CA-8 Revised Nov. 1974

PERFORMANCE TEST
SMITH CASE
TASK I

2nd Surgery

March 4, 1982

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Smith, Paul E.
DOI: 02/14/80

Dear Sir:

This is a 36 year old man who was admitted with post-traumatic arthritis of the MP joint, right great toe. He has a failed Keller bunionectomy and now is admitted for arthrodesis of the MP joint.

HOSPITAL COURSE: On 3-3-82, arthrodesis of the MP joint, right great toe, done with internal K wire fixation. He is currently recovered from surgery and anesthesia. He is ambulating with crutches and is allowed to be discharged home. He will be followed in the office on 3-8-82, given a prescription for Vicodan to use for pain.

DIAGNOSIS: Traumatic arthritis, MP joint, right great toe. Failed Keller bunionectomy, right great toe.

OPERATIVE PROCEDURE: Arthrodesis, MP joint, right great toe.

Sincerely,

A. A. Kirk, M.D.

Copy to:
Norfolk Naval Shipyard

PERFORMANCE TEST
SMITH CASE
TASK I

February 16, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Smith, Paul E.
DOI: 02/14/80

Dear Sir:

Mr. Smith was seen in our office on 2/14/83, two years since his injury. At that time his foot was improving.

On examination, the metatarsophalangeal joint of the right great toe is solid and stable. The joint was not tender but he did have some soreness over the lateral side of his foot and he seemed to be walking over the lateral side. He has a wedge in his shoe that does help to some degree.

He was asked to return in one month and I felt that he will be able to return to work maybe at that time.

Sincerely,

A. A. Kirk, M.D.

Copy to:
Norfolk Naval Shipyard

PERFORMANCE TEST
SMITH CASE
TASK I

In your review Mr. Smith's case case file, assume today's date is 4/6/83.

14. Which one of the following courses of action would you take at this time. Mark the letter of your choice on your Answer Sheet.

    a. Request that the attending physician submit a reevaluation, including work restrictions

    b. Require that Mr. Smith have a Fitness for Duty physical examination

    c. There is no need to do anything at this point; wait for the next physician's report

PERFORMANCE TEST
SMITH CASE
TASK II

You have received the report which follows on page 47 from the attending physician dated May 9, 1983. Review it and then answer the question on page 48.

PERFORMANCE TEST
SMITH CASE
TASK II

May 9, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Smith, Paul
DOI: 2/14/80

Dear Sir:

Mr. Smith was seen in the office on 5/6/83. It is my opinion that he has reached maximum medical improvement. He has a fifty (50%) percent permanent partial disability of his right foot because of ankylosis of the metalarsophalangeal joint of the great toe as a result of an injury at work on 2/14/80.

Mr. Smith is released from care at this time.

Sincerely,

A. A. Kirk, M. D.

Copy to:
Norfolk Naval Shipyard

PERFORMANCE TEST
SMITH CASE
TASK II

15. Select the next course of action to take. Mark the letter of your selection on your Answer Sheet.

    a. Notify Mr. Smith of a date to report to work.

    b. Require Mr. Smith to take a Fitness for Duty physical exam.

    c. Ask the attending physician for Mr. Smith's work limitations.

    d. Request OWCP to give a Loss of Wage Earning Capacity rating (LWEC) for Mr. Smith.

PERFORMANCE TEST
SMITH CASE
TASK III

You receive the information on pages 50 and 51 from the attending physician dated July 21. After examining it, go to page 52 and answer the question.

PERFORMANCE TEST
SMITH CASE
TASK III

July 21, 1983

Office of Workers' Compensation
666 11th Street, N.W.
Washington, D.C. 20211

RE: Smith, Paul E.
DOI: 2/14/80

Dear Sirs:

The above patient was seen in the office on July 18, 1983, at which time he stated his right foot was giving him some discomfort - especially when he has to walk for any significant distance.

I gave him a prescription and asked him to return only as necessary. I also feel he can return to work at this time. Enclosed is a work restriction evaluation sheet which I have completed.

Sincerely yours,

A. A. Kirk, M. D.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

WORK RESTRICTION EVALUATION

1. Injured workers' name *(First, middle, last)* Smith, Paul E

2. OWCP No.

ACTIVITY TYPE

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY								
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8
a. Sitting	✓										✓
b. Walking		✓							✓		
c. Lifting		✓					✓				
d. Bending		✓							✓		
e. Squatting		✓							✓		
f. Climbing		✓				✓					
g. Kneeling		✓				✓					
h. Twisting		✓							✓		
i. Standing		✓							✓		

4. Check the lifting restriction.
☐ 0–10 lbs. ☐ 10–20 lbs. ☑ 20–50 lbs. ☐ 50–75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?
☑ No ☐ Yes – *(Check b, c, and d.)*

5b. Simple grasping?
☐ Yes ☐ No

5c. Pushing and pulling? ☐ Yes ☐ No

5d. Fine manipulation? ☐ Yes ☐ No

6. Can the worker reach or work above the shoulder? ☑ Yes ☐ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement? ☐ Yes ☐ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle? ☑ Yes ☐ No

9. Are there cardiac, visual, or hearing limitations?
☐ No ☑ Yes – *(Describe)*

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases? ☑ No ☐ Yes – *(Describe)*

11. Are interpersonal relations effected because of a neuropsychiatric condition?
☑ No ☐ Yes – Describe *(Ability to give and take supervision, meet deadlines, etc.)*

RECOVERY DEGREE

12a. Can the individual work eight hours a day?
☑ Yes ☐ No – *(Indicate when)*

12b. If not eight hours, how many and when?

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work? ☐ Yes ☑ No

14. Has the worker reached maximum improvement?
☑ Yes *(Indicate when)* 7/21/83 ☐ No *(Indicate when)*

PHYSICIAN

15. Remarks: *(Restrictions from medication or other limitations)*

16. Name R. A. Kirk

17. Signature

18. Address 3636 High Street
Portsmouth, Va

19. Telephone No. (804) 393-1212

20. Date 7/21/83

Copy Distribution: WHITE – Carrier/Employer YELLOW – OWCP Case File PINK – OWCP Rehab. File

Form OWCP-5
Sept. 1979

16. Given the information in this correspondence, on your Answer Sheet mark the letter of the option below that would most likely resolve this case.

    a. Request an LWEC rating from OWCP.

    b. Recommend to OWCP that they assign the case to vocational rehabilitation.

    c. Offer the claimant a modified job within the agency.

    d. Case cannot be resolved at present (compensation will be continued).

PERFORMANCE TEST
CRAWFORD CASE
TASK I

Review the following case file for Cory Crawford on pages 54 - 65. He is on the periodic roll and has been separated from your agency. Then go to page 66 and answer the question.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee (Last, first, middle)	2. Date of Birth	3. ☑ Male ☐ Female	4. Social Security Number
Crawford, Cory	8-15-30		336-48-7126

5. Employee's Home Mailing Address (No., street, city, state, zip code)	6. Home Telephone Area Code: 312 Number: 487-3628
901 E. Green, Maywood Ill. 60153	

7. Name and Address of Employing Agency	8. Place Where Injury Occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)
North Suburban MSC	Postal Service Parking Lot

9. Date and Hour of Injury (mo., day, year)	10. Date of This Notice (mo., day, year)	11. Dependents	12. Employee's Occupation
3/16/79 3:35 ☐ AM ☑ PM	3/16/79	Wife/Husband ☑ Children Under 18 Years Old ☑	RMH

13. Cause of Injury (Describe how and why the injury occurred)	14. Nature of Injury (Identify the part of the body injured, e.g., fractured left leg, etc.)
While cleaning snow off car slipped and fell	R Knee Bruised and painful unable to stand

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Cory Crawford
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness (Describe what you saw, heard or know about this injury)

18. Witness' Signature	19. Witness' Address	20. Date Signed (mo., day, year)

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency: U.S. Postal Service

22. Bureau or Office:

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*: 8999 Palmer Maywood, Ill

24. Regular Work Day — Begins 7:00 ☐ AM ☐ PM — Ends 3:30 ☐ AM ☑ PM

25. Number of Hours Worked Per Day: 8

26. Circle Days Paid Per Week: S M (T) (W) (T) (F) S

27. Date and Hour of Injury *(mo., day, year)*: 3/16/79 ☐ AM ☑ PM 3:3[illegible]

28. Date Reporting Office Received Notice of Injury *(mo., day, year)*: 3/16/79

29. Date and Hour Stopped Work *(mo., day, year)*: 3/16/79

30. If Pay Has Been Terminated, Give Date *(mo., day, year)*:

31. 45 Day Period Begins *(mo., day, year)*: 3/17/79

32. Pay Rate When Employee Stopped Work: $ 8. per 65'

33. Date and Hour Employee Returned to Work *(mo., day, year)* ☐ AM ☐ PM: Absent returned

34. Name of Supervisor At Time of Injury: Ann Jenkins

35. Was Employee In Performance of Duty At The Time of Injury? ☐ Yes, ☑ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

Clmt had ended tour of duty and was on his way home

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?

☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*: 3/16/79

39. Name and Address of Physician First Providing Medical Care: Henrotin Hospital Clmt was admitted

40. Do Medical Reports Show Employee is Disabled For Work? ☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness? ☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor: Ann Jenkins

44. Title and Office Phone Number: Supv of Mails

45. Date *(mo., day, year)*: 3/20/79

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Denrotin Hospital

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Crawford, Cary	3-16-79	RMA

5. DESCRIPTION OF INJURY OR DISEASE

Clmt fell in parking lot injuring R knee unable to put weight on R leg knee painful and swollen

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Ruby Harris	RN
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
561-3631	3-16-79

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address):	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency Bureau or Office Local Address (Including Zip Code)

FORM CA–16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle)
Crawford, Cary

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?
fell in Parking Lot

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)
☑ Yes ☐ No

17. WHAT ARE YOUR FINDINGS (include results of x-rays, laboratory tests, etc.)?
Patella Drug reveal frks after

18. WHAT IS YOUR DIAGNOSIS?
Patella frks

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)
☑ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION? ☑ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED?
☐ Yes ☑ No

22. SURGERY (If any, describe type)
Reconstruction of Right Knee

23. DATE SURGERY PERFORMED (mo., day, year) 3/17/79

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
Conservative Care

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
Unable to determine at this time

26. DATE OF FIRST EXAMINATION (mo., day, year)
3/16/79

27. DATE(S) OF TREATMENT (mo., day, year)
4/3/79

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM 3/16/79 TO
PARTIAL DISABILITY: FROM TO

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK approx. 6 mos
REGULAR WORK

31. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☑ NO IF YES, FURNISH DATE ADVISED (month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.
Clmt was discharged from Hospital 4/1/79

34. DO YOU SPECIALIZE? ☑ Yes ☐ No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN
Lloyd Riordan, MD

36. ADDRESS (Number, street, city, state, zip code)
318 So Michigan
Chgo Ill

37. PHYSICIAN'S SOCIAL SECURITY NUMBER
8-332

38. DATE OF REPORT (mo., day, year)
4/5/79

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price: Cost	Unit price: Per	Amount: $	Amount: ¢
	TOTAL					

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U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES

Lloyd Riordan, M.D.

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Crawford, Cory	3-16-79	Rmn	336-48-7126

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.

R Knee

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS

Mails & Vehicals trucks must be able to lift up to 70 lbs

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS			✓
HEAVY – LIFTING 50 to 100 POUNDS 70			✓
PULLING/PUSHING, CARRYING			✓
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (8 HOURS)			✓
STANDING (8 HOURS)			✓
SITTING (HOURS)	✓		
STOOPING (HOURS)			✓
KNEELING (HOURS)			✓
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

U.S. Postal Service
Injury Comp Unit
North Suburban, MSC
60199

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B — PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in Item 7)?* ☐ YES ☐ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY — LIFTING 0 to 10 POUNDS			
LIGHT — LIFTING 10 to 20 POUNDS			
MODERATE — LIFTING 20 to 50 POUNDS			
HEAVY — LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS
L Knee pt's lt Patella reconstruction Surgery of R Knee no weight bearing Cont Rehabilitation

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM 3/16/79 TO
PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☐
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY
see above

17. DATE OF EXAMINATION

18. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Lloyd Richman M.D

20. PROFESSIONAL DEGREE
Orthopedics

21. DATE *(Mo., day, year)*
3/30/79

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs (OWCP)

CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*: Crawford, Cary

2. Social Security Number: 336-48-7126

3. OWCP File Number *(If known)*: A10-267186

4. Is Claim Being Made For Wage Loss? ☑ Yes ☐ No

5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body? ☐ Yes ☑ No

6. Period Compensation Is Claimed As A Result Of Wage Loss *(Mo., day, year)*: From: 4-30-79 Through: present

7. Has Any Pay Been Received For The Period Shown In Item 6? ☐ Yes ☑ No If Yes, State Full Amount And Inclusive Dates For Such Period *(Mo., day, year)*: $ _____ From: _____ Through: _____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☑ No
If Yes, Give Name And Address Of Such Party Or Insurance Carrier

9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States? ☐ Yes ☑ No If Yes, Furnish →

a. Service Number	b. Branch Of Service	c. Period Of Service *(Mo, day, year)*
		From: _____ Through: _____

11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? NA
☐ Yes ☐ No If Yes, Furnish →

a. Claim Number	b. Address of VA Office Where Claim Is Filed	c. Nature Of Disability And Monthly Payment

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? ☐ Yes ☑ No If Yes, Furnish →

a. Claim Number	b. Date Annuity Began *(Mo., day, year)*	c. Amount of Monthly Payment
		$ _____

13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? *(Yes/No)*	Mailing Address, If Different From Your Own
Christine	wife	5/30/34	yes	
Carla	daughter	11-10-67	yes	
Carl	son	11-10-67	yes	
Cornell	son	7-3-70	yes	

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

15. Employee's Signature	16. Employee's Home Mailing Address *(Include Zip Code)*	17. Date *(Mo., day, year)*
Corey Crawford	901 E. Green Maywood Ill 60153	5-30-79

Form CA-7
Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office *(Number, street, city, state, zip code)*
North Suburban, MSC 8999 Palmer

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
Date of Injury →	$ 29 per 500 yrly	$ per	$ per	$ per
Date Employee Stopped Work →	$ 29 per 500 yrly	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount
Type N/A $ _____ per _____

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?
☑ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?
☐ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service
13 yrs

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes
$ 29,500 per yrly

27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave
From: 3/17/79 Through: 4-29-79

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$ 2,864.09

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
	$ per	$ per	$ per	$ per

PART D – COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*
4-30-79 ☐ AM ☐ PM

31. Period For Which Compensation Is Claimed
From: 4-30-79 Through: present

32. Deductions:
a. Was Employee Enrolled On Date Pay Stopped? Health Benefits ☑ Yes ☐ No; Optional Insurance ☑ Yes ☐ No
b. If Yes, Furnish Code Number. 202
c. If Yes, Give Date Through Which Deductions Were Last Made.

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*
Hasn't returned ☐ AM ☐ PM

34. Pay Rate At Time Returned To Work
$ _____ per _____

35. Show Work Week On Return To Work If Other Than Monday Through Friday
S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F – CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*
Hazel Green	TCS 771-5300	5/30/79

CA-7
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*: Crawford, Carey

2. HOME MAILING ADDRESS *(Number, street, city, state, zip code)*: 901 E. Green Maywood 60153

3. DATE AND HOUR OF INJURY *(Mo., day, year)*: 3-16-79 3:35 ☐ AM ☑ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS *(Mo., day, year)*: FROM 4-30-79 TO Present

5. WHAT HISTORY OF INJURY *(including disease caused by the employment)* DID EMPLOYEE GIVE YOU?
Pt reports fell on Right Knee in Parking lot

6. WHAT ARE YOUR FINDINGS *(Include results of x-rays, laboratory tests, etc.)*?
fractured patella on the right x-rays reveal and degenerative changes

7. WHAT IS YOUR DIAGNOSIS?
Frx of Patella

8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? *(Please explain your answer if there are doubts)*
☑ YES ☐ NO

DID INJURY REQUIRE HOSPITALIZATION? ☑ YES ☐ NO
IF YES, DATE OF ADMISSION *(Mo., day, year)*
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ YES ☐ NO

11. OPERATIONS *(If any, describe type)*: 3/17/79

12. DATE OPERATIONS PERFORMED *(Mo., day, year)*: 3/17/79

13. WHAT *(Other)* TYPE OF TREATMENT DID YOU PROVIDE?
Conservative Care following Surgery
NO Weight bearing as yet

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
?

15. DATE OF FIRST EXAMINATION *(Mo., day, year)*: 3/16/79

16. DATES OF TREATMENT *(Mo., day, year)*:

17. DATE OF DISCHARGE FROM TREATMENT *(Mo., day, year)*:

18. PERIOD OF DISABILITY *(If termination date unknown, so indicate)* *(Mo., day, year)*
TOTAL DISABILITY: FROM 3/16/79 TO approx 6 Mos
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME *(Mo., day, year)*
LIGHT WORK
REGULAR WORK

20. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE BEEN ADVISED? ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED.

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.

23. SIGNATURE OF PHYSICIAN: Lloyd Riordan

24. ADDRESS *(Number, street, city, state, zip code)*: 2600 W. Michigan

25. DATE OF REPORT *(Mo., day, year)*: 5-30-79

CA-20
Rev. Feb. 1975

PERFORMANCE TEST
CRAWFORD CASE
TASK I

10/11/79

U.S. Labor Dept.
OWCP, 8th Floor
Chicago, Ill. 60604

Dear Sir/Madam:

Mr. Crawford was examined by me today. He was accompanied by his wife who assisted him into the office. Mr. Crawford is complaining of pain and swelling of the right knee. Exam of the right knee reveals flexion only to 20, instability of the right knee with moderate effusion, uncomferential measurements of the thigh, right is 14 1/2, left is 15 1/2 inches. Knee right is 14 1/4 the left knee is 13 7/8 inches. There is moderate atrophy of the right leg. Xrays taken today reveal the patella is in its normal relationship to the lower end of the femur. There is however, irregularity of the mid portion of the articular aspect of the patella. The calcification of the quadriceps tendon on the anterior superior aspect of the patella is well visualized. Mr. Crawford has been given a knee immobilizer to aid in stability while ambulating. He is to continue his physical therapy which had been interrupted pending this exam. He continues to be totally disabled and I will see him again in 2 mos.

Floyd Riordan, M.D.

PERFORMANCE TEST
CRAWFORD CASE

12/20/79

To Whom it Concerns:

Mr. Crawford was examined by me today and still complains of pain and stiffness. However, upon examination there was no swelling or discoloration. The surgical scar was cool and dry. Range of motion manipulations of the patella were within normal limits. Mr. Crawford however, should avoid prolonged periods of standing, walking and no lifting over 50 lbs.

From an orthopedic stand point Mr. Crawford can return to work with the above restrictions. However, Mr. Crawford informs me he is being seen by a cardiologist and has been diagnosed as having a severe heart condition which precludes him from returning to work. I informed him that this problem was beyond the realm of my expertise, and I could not comment on that particular disability. I have enclosed the completed OWCP 5 form as requested. It is my opinion that Mr. Crawford can return to work with the restrictions I have outlined.

Floyd Riordan, M. D.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

WORK RESTRICTION EVALUATION

1. Injured workers' name *(First, middle, last)* Crawford, Carey

2. OWCP No. AR-367186

ACTIVITY TYPE

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY								
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8
a. Sitting											✓
b. Walking		✓			✓						
c. Lifting			✓								
d. Bending			✓								
e. Squatting			✓								
f. Climbing			✓								
g. Kneeling			✓								
h. Twisting		✓			✓						
i. Standing		✓			✓						

4. Check the lifting restriction.
☐ 0–10 lbs. ☐ 10–20 lbs. ☑ 20–50 lbs. ☐ 50–75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?
☑ No ☐ Yes – *(Check b, c, and d.)*

5b. Simple grasping?
☐ Yes ☐ No

5c. Pushing and pulling? ☐ Yes ☐ No

5d. Fine manipulation? ☐ Yes ☐ No

6. Can the worker reach or work above the shoulder? ☐ Yes ☐ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement? ☐ Yes ☑ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle? ☐ Yes ☑ No

9. Are there cardiac, visual, or hearing limitations?
☐ No ☑ Yes – *(Describe)*

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases? ☑ No ☐ Yes – *(Describe)*

11. Are interpersonal relations effected because of a neuropsychiatric condition?
☑ No ☐ Yes – Describe *(Ability to give and take supervision, meet deadlines, etc.)*

RECOVERY DEGREE

12a. Can the individual work eight hours a day?
☑ Yes ☐ No – *(Indicate when)*

12b. If not eight hours, how many and when?

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work? ☐ Yes ☑ No

14. Has the worker reached maximum improvement?
☑ Yes *(Indicate when)* ☐ No *(Indicate when)*

PHYSICIAN

15. Remarks: *(Restrictions from medication or other limitations)*

16. Name

17. Signature

18. Address Lloyd Riordan, MD

19. Telephone No. 362-1143

20. Date 12/20/79

Copy Distribution: WHITE – Carrier/Employer YELLOW – OWCP Case File PINK – OWCP Rehab. File

Form OWCP-5
Sept. 1979

SPO 681 640

17. On the basis of your review of Cory Crawford's file, on the Answer Sheet mark the letter of the item below that is most critical to the resolution of this case:

    a. The job-related knee injury is not preventing the claimant from returning to work

    b. There is no medical evidence supporting the claimant's contention that he has a serious heart condition

    c. The medical evaluation, including work restrictions, is more than six months old

    d. The claimant told the orthopedist that he could not return to work, even if his knee was better, because he has a serious heart condition.

PERFORMANCE TEST
CRAWFORD CASE
TASK II

Review the job description on page 68 for Cory Crawford's former job. Also examine the work restriction evaluation on page 65. Then go to page 69 and answer the question.

TITLE: DISTRIBUTION CLERK
POSITION NUMBER: KP-12
LEVEL: PS-5
OCCUPATIONAL CODE: 2315-04

BASIC FUNCTION: Separates mail in a post office, terminal, airmail field, or other postal facility in accordance with established schemes, including incoming or outgoing mail or both.

DUTIES AND RESPONSIBILITIES

(A) Makes primary and one or more secondary distributions of incoming mail by delivery point (for example, classified or contract station or branch or other delivery unit, general delivery, lockboxes, rural or star route, or city carrier route) based on a knowledge of the distribution scheme established for that office.

(B) Makes primary and one or more secondary distributions of outgoing mail for dispatch (for example, by city, state, region, train, highway or railway post office or airmail flight) based on a knowledge of the distribution scheme prescribed by the Postal Transportation Service.

(C) In addition, may perform any of the following duties:

1. Maintains records of mails.
2. Examines balances in advance deposit accounts.
3. Faces and cancels mail.
4. Ties mail and inserts facing slips.
5. Opens and dumps pouches and sacks.
6. Operates cancelling machines.
7. Records and bills mail (for example, c.o.d. registered, and so forth) requiring special service.
8. Renders service at public windows.

ORGANIZATIONAL RELATIONSHIPS: Reports to a foreman or other designated supervisor.

PHYSICAL REQUIREMENTS

(A) Must be physically able to handle heavy sacks of mail. On outside assignments this work is performed in all kinds of weather. In most instances, an amputation of arm, hand, leg, or foot will not disqualify an applicant for appointment, although it may be necessary that this condition be compensated by use of satisfactory prosthesis. The distant vision required must test 20/40 (Snellen) in one eye, glasses permitted. Generally, applicants must be able to hear ordinary conversation with or without a hearing aid but some positions may be filled by the deaf. Color vision is not required for these positions.

PERFORMANCE TEST
CRAWFORD CASE
TASK II

Is there any conflict between the physical demand of his former job (page 68) and the work limitations imposed by the 12/20/79 work restriction evaluation (page 65)? On the Answer Sheet, mark the letter of the best response.

18. a. Yes

    b. No

    c. Do not have enough information to tell.

19. Which of the following <u>additional</u> questions about the physical requirements of the job (page 68) must be answered? (You need to identify all possible conflicts between the job description and Cory Crawford's work limitations.) On your Answer Sheet, mark one or more correct answers.

    a. Is more than intermittent standing or walking required?

    b. Is anything beyond intermittent lifting required?

    c. Is any bending, squatting, climbing or kneeling required?

    d. Do mail sacks sometimes weigh over 50 lbs.?

    e. None of the above.

PERFORMANCE TEST
CRAWFORD CASE
TASK III

Additional information has been provided on the job's physical requirements. It includes the following statement:

"The incumbent must be able to perform arduous exertion involving prolonged standing, walking, distributing and reaching."

20. Based on all of the job's physical requirements and the previous Work Restriction Evaluation, select the best answer below and mark it on your Answer Sheet:

    a. There is no conflict in work restrictions - bring employee back to work

    b. There is a conflict between the physical demand of this job and the work limitations - the requirements of sitting, prolonged walking and kneeling are violated.

    c. There is a conflict between the physical demand of this job and the work limitations - the requirements of prolonged walking, heavy lifting, and standing continuously are violated.

    d. There is a conflict between the physical demand of this job and the work limitations - the requirements of prolonged sitting, prolonged walking and bending are violated.

PERFORMANCE TEST
CRAWFORD CASE
TASK IV

Read the following material: a recent medical report on Mr. Crawford, updated work limitations, and a letter from Larry Taylor, a vocational rehabilitation counselor which you later received in the mail (pages 72 - 74). Then go to page 75 and answer the question.

PERFORMANCE TEST
CRAWFORD CASE
TASK IV

March 28, 1984

U.S. Labor Department
OWCP 8th Floor
Chicago, Ill 60604

Ref: Cory Crawford

Mr. Crawford was examined in my office today. Examination today is basically unchanged from my exam of 1979. Mr. Crawford still complains of pain and stiffness of the right knee. Range of motion and manipulations of the patella were within normal limits. Knee jerks were swift and brisk. No atrophy of the quadriceps was present. Mr. Crawford is able to heel and toe bilaterally. Mr. Crawford from an orthopedic stand point is capable of returning to work in the modified position described by Mr. Taylor, the Rehab consultant who accompanied him here. I have completed the OWCP 5 outlining Mr. Crawford's limitations. As before, I cannot comment on Mr. Crawford's heart problems since it is outside of my field of expertise.

Sincerely,

Floyd Riordan, M.D.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

WORK RESTRICTION EVALUATION

1. Injured workers' name *(First, middle, last)* Mary Crawford

2. OWCP No.

ACTIVITY TYPE

3. Check the frequency and number of hours a day the worker is able to do the following specific types of activities.

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY								
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8
a. *Sitting*											✓
b. *Walking*		✓			✓						
c. *Lifting*			✓								
d. *Bending*			✓								
e. *Squatting*			✓								
f. *Climbing*			✓								
g. *Kneeling*			✓								
h. *Twisting*		✓			✓						
i. *Standing*		✓			✓						

4. Check the lifting restriction.
☐ 0–10 lbs. ☐ 10–20 lbs. ☑ 20–50 lbs. ☐ 50–75 lbs. ☐ 75 & above lbs.

5a. Hand restrictions?
☑ No ☐ Yes – *(Check b, c, and d.)*

5b. Simple grasping?
☐ Yes ☐ No

5c. Pushing and pulling? ☐ Yes ☐ No

5d. Fine manipulation? ☐ Yes ☐ No

6. Can the worker reach or work above the shoulder? ☑ Yes ☐ No

7. Can the worker use his/her feet to operate foot controls or for repetitive movement? ☐ Yes ☒ No

8. Can the worker operate a car, truck, crane, tractor, or other type of motor vehicle? ☐ Yes ☒ No

9. Are there cardiac, visual, or hearing limitations?
☐ No ☐ Yes – *(Describe)* Not to may field of vision

10. Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases? ☒ No ☐ Yes – *(Describe)*

11. Are interpersonal relations effected because of a neuropsychiatric condition?
☒ No ☐ Yes – Describe *(Ability to give and take supervision, meet deadlines, etc.)*

RECOVERY DEGREE

12a. Can the individual work eight hours a day?
☑ Yes ☐ No – *(Indicate when)*

12b. If not eight hours, how many and when?

13. Do you anticipate the worker will need vocational rehabilitation services such as testing, counseling, training, or placement to return to work? ☐ Yes ☒ No

14. Has the worker reached maximum improvement?
☐ Yes *(Indicate when)* 6 mos after surgery ☐ No *(Indicate when)*

PHYSICIAN

15. Remarks: *(Restrictions from medication or other limitations)* Based on the enclosed job description of a Medical Assistant Mary Crawford will be able to work with this job

16. Name Lloyd Riordan, M.D.

17. Signature Lloyd Riordan, M.D.

18. Address 2000 W. Michigan Avenue

19. Telephone No. 362-1143

20. Date 3/25/87

Copy Distribution: WHITE – Carrier/Employer YELLOW – OWCP Case File PINK – OWCP Rehab. File

Form OWCP-5
Sept. 1979

PERFORMANCE TEST
CRAWFORD CASE
TASK IV

March 28, 1984

U.S. Labor Department
OWCP, 8th Floor
Chicago, Ill 60604

ATT: Kathleen Marr
Rehabilitation Specialist, CRS

Thank you for your referral of Mr. Cory Crawford for our rehabilitation assistance in returning him to work. The case history reveals Mr. Crawford is a 54 year old former mailhandler for the U.S. Postal Service, who on 3/16/79 fell and injured his right knee. I initially visited with Mr. Crawford in his home on 2/6/84 to discuss our involvement and program with him. Mr. Crawford informed me he was not interested in returning to work and explained he has a severe heart condition and cannot do any work. Mr. Crawford upon further questioning reported he was going to see his cardiologist the following Monday. I asked Mr. Crawford if I could attend the examination with him. Mr. Crawford was at first reluctant to this suggestion but in the end he agreed. On 2/11/84 I visited with cardiologist, Jacob Einer, M.D. Dr. Einer upon completion of his exam with the Clmt spent a few minutes with me and the clmt discussing the clmt's heart condition. Dr. Einer was informed by me that the clmt would be offered a modified job with the U.S. Postal Service. Detailing the specifics of the job to be offered, I asked Dr. Einer based on his opinion would Mr. Crawford be able to return to work. Dr. Einer however reported the claimant can not return to work in any capacity, stating the claimant has arteriosclerotic heart disease and suffers from chronic angina. Any stress or strain which Dr. Einer feels would be promoted by his returning to work at the Post office could cause an exaerbation of the present symptoms, and cause a myocardial infarct or worse.

It should be noted, Mr. Crawford does complain of chest pain upon any physical exertion. Mr. Crawford has an appt. with orthopedist Floyd Riordan, M.D. on 3/28/84 at which time I will be in attendance to discuss and explain my involvement in this case.

I will keep you informed of this case as it develops.

Sincerely,

Larry Taylor
Vocational Rehabilitation Consultant

PERFORMANCE TEST
CRAWFORD CASE
TASK IV

21. Given this new information, indicate which of the actions described below you should take. On your Answer Sheet, mark the letter of the best answer.

    a. Since you now have evidence that the claimant is unemployable, you would request an LWEC rating from OWCP.

    b. Since you now have an indication that the claimant is totally disabled, the case cannot now be resolved (compensation will continue).

    c. Since there is no medical evidence of the claimant's alleged heart condition, a complete medical report is needed on this condition including the work restrictions that result from it.

    d. Prepare to make a job offer that accommodates the claimant's work limitations (and any pre-existing condition).

PERFORMANCE TEST
CRAWFORD CASE
TASK V

Read the "Modified Distribution Clerk Duties and Requirements" on page 77 which you have prepared. It is approved by Dr. Riordan as being within Mr. Crawford's work limitations.

The job offer is made and Mr. Crawford refused. Larry Taylor, the vocational rehabilitation counselor, reported this to OWCP. Read his letter following the job description on page 78. Then answer the question on page 79.

PERFORMANCE TEST
CRAWFORD CASE
TASK V

Modified Distribution Clerk, Duties and Requirements

Mr. Crawford will be reemployed as a modified Distribution Clerk. This job consists of the following:

Mr. Crawford will be seated in a stenographer chair with back support at a modified distribution letter case. This case will allow him access to the pigeon holes without having to reach over shoulder level to distribute the letters. Mr. Crawford's physical requirements for fulfilling this task will be the ability to lift letter trays which weigh 18 to 20 lbs when full. Mr. Crawford will replenish the ledge of his letter case with additional letters as the need arises. He may do this by either taking handfuls of letters at a time and bringing them to his case or he may lift and carry a tray of letters to his case for processing. Mr. Crawford will not be required to work at a competitive pace. He may change positions from sitting to standing intermittently as his physical comfort warrants. The ability to walk into and from the work are in addition to walking twenty feet intermittently to the guerney which holds the letter trays for replenishing his mail.

This job will be at the same grade and step as he held at the time of injury.

PERFORMANCE TEST
CRAWFORD CASE
TASK V

U. S. Labor Department
OWCP, 8th Floor
Chicago, Ill 60604

ATT: Rehabilitation Specialist
Kathleen Marr, CRS

REF: Cory Crawford

I have been in contact with the North Suburban Post Office and have provided them with a copy of the medical report and work tolerances provided by Dr. Riordan. I also pointed out to them that Mr. Crawford has a heart problem. However, on 4/20/84, Mr. Crawford was examined by them for a pre-employment physical. It appears Mr. Crawford has been deemed employable by their medical doctor and they have offered him the modified position as has been discussed. Mr. Crawford as he indicated to me beforehand did not accept reemployment with the Postal Service.

Sincerely,

Larry Taylor

PERFORMANCE TEST
CRAWFORD CASE
TASK V

You decide to request termination of this claimant's benefits.

22. Which item(s) below are <u>not</u> <u>essential</u> to your documentation of this case for OWCP. Mark the letter(s) of the best answer(s) on your Answer Sheet. Refer back to the file on pages 53 - 78 if necessary.

    a. Job duties and requirements with written approval by Dr. Riordan

    b. Information supplied by Dr. Einer, a cardiologist, saying that Mr. Crawford was totally disabled from all employment as a result of a heart condition

    c. Work limitations assigned by Dr. Riordan

    d. Mr. Crawford's written declination of the job offered him

    e. An indication of the grade and pay of the job offered Mr. Crawford.

PERFORMANCE TEST
JENKINS CASE
TASK I

Shirley Jenkins was separated from the Agency 10/1/83. Review the following material on pages 70 - 80 for her case. Then go to page 92 and answer the question.

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

FEDERAL EMPLOYEE'S NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF PAY/COMPENSATION

1. Name of Injured Employee *(Last, first, middle)*	2. Date of Birth	3. ☐ Male ☑ Female	4. Social Security Number
Jenkins, Shirley A	3/27/47		432-72-2136

5. Employee's Home Mailing Address *(No., street, city, state, zip code)*	6. Home Telephone Area Code: Number:
2110 So. Damen Chicago Ill 60608	312 661-0178

7. Name and Address of Employing Agency	8. Place Where Injury Occurred *(e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)*
Chicago Main P O 433 W Harrison Chicago Ill 60608	Oak & Damen

9. Date and Hour of Injury *(mo., day, year)*	10. Date of This Notice *(mo., day, year)*	11. Dependents	12. Employee's Occupation
4/12/78 9:35 ☑ AM ☐ PM	4/12/78	Wife/Husband ☐ Children Under 18 Years Old ☐	Letter Carrier

13. Cause of Injury *(Describe how and why the injury occurred)*	14. Nature of Injury *(Identify the part of the body injured, e.g., fractured left leg, etc.)*
Stepped in a hole while leaving the street	R ankle. Sprain

15. If This Notice and Claim Was Not Filed With The Employing Agency Within 2 Working Days After The Injury, Explain The Reason For The Delay.

16. I certify that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Sick and/or annual leave

☑ b. Continuation of regular pay not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days (If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584).

Shirley A. Jenkins
Signature of Employee or Person Acting on His/Her Behalf

17. Statement of Witness *(Describe what you saw, heard or know about this injury)*

18. Witness' Signature	19. Witness' Address	20. Date Signed *(mo., day, year)*

Form CA-1
Rev. Nov. 1974

OFFICIAL SUPERIOR'S REPORT OF TRAUMATIC INJURY

21. Department or Agency	22. Bureau or Office
U.S. Postal Service	

23. Name and Address of Reporting Office *(No., street, city, state, Zip Code)*
433 W. Van Buren Chicago Ill 60607

24. Regular Work Day	25. Number of Hours Worked Per Day	26. Circle Days Paid Per Week
Begins 6:30 ☑ AM ☐ PM Ends 2:30 ☐ AM ☑ PM	8	S M T W T F S

27. Date and Hour of Injury *(mo., day, year)*	28. Date Reporting Office Received Notice of Injury *(mo., day, year)*	29. Date and Hour Stopped Work *(mo., day, year)*	30. If Pay Has Been Terminated, Give Date *(mo., day, year)*
4/13/78 9:30a ☑ AM ☐ PM	4/13/78	4/13/78	

31. 45 Day Period Begins *(mo., day, year)*	32. Pay Rate When Employee Stopped Work	33. Date and Hour Employee Returned to Work *(mo., day, year)*	34. Name of Supervisor At Time of Injury
4/13/78	$ 4.44 per hr	☐ AM ☐ PM	Charles Daniels

35. Was Employee In Performance of Duty At The Time of Injury? ☑ Yes, ☐ No. If No, Furnish A Detailed Explanation Or A Copy of Employing Agency's Investigation Report.

36. Was Injury Caused By Willful Misconduct, Intoxication or Intent To Injure Self or Another?
☐ Yes ☑ No. If Yes, Furnish Detailed Report.

37. Was Injury Caused By Third Party? ☐ Yes ☑ No. If Yes, Furnish Name and Address of Party Responsible.
Clmt was jogging her mail and mat watching where she was walking

38. Date Employee First Obtained Medical Care for The Injury *(mo., day, year)*	39. Name and Address of Physician First Providing Medical Care	40. Do Medical Reports Show Employee Is Disabled For Work?
4/13/78	Presbyterian St Lukes Emergency Rm	☑ Yes ☐ No

41. Does Your Knowledge of The Facts About This Injury Agree With The Statements of The Employee And/Or Witness?
☑ Yes ☐ No. If No, Furnish A Detailed Explanation.

42. Does The Employing Agency Controvert Continuation of Pay? ☐ Yes ☑ No. If Yes, Give Full Explanation For Basis of Controversion (See Item 6 of Instruction Sheet). Attach Additional Sheets If More Space Is Needed.

43. Signature of Supervisor	44. Title and Office Phone Number	45. Date *(mo., day, year)*
Charles Daniels	Foreman of Mails	4/14/78

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

REQUEST FOR EXAMINATION AND/OR TREATMENT

PART A – AUTHORIZATION

1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE

Presbyterian St. Luke Hosp
1735 W. Harrison, Chgo. Ill 60608

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (mo., day, year)	4. OCCUPATION
Gearins, Shirley A	4/12/78	Letter Carrier

5. DESCRIPTION OF INJURY OR DISEASE

Pt stepped in a hole while crossing the street twisted left ankle

6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS:

☑ A - FURNISH OFFICE AND/OR HOSPITAL TREATMENT AS NECESSARY FOR THE EFFECTS OF THIS INJURY. ANY SURGERY, OTHER THAN EMERGENCY, MUST HAVE PRIOR OWCP APPROVAL.

☐ B - THERE IS DOUBT WHETHER THE EMPLOYEE'S CONDITION IS CAUSED BY AN INJURY SUSTAINED IN THE PERFORMANCE OF DUTY OR IS OTHERWISE RELATED TO HIS EMPLOYMENT. YOU ARE AUTHORIZED TO EXAMINE THE EMPLOYEE, USING INDICATED NON-SURGICAL DIAGNOSTIC STUDIES, AND PROMPTLY ADVISE THE UNDERSIGNED WHETHER YOU BELIEVE THE CONDITION IS DUE TO THE ALLEGED INJURY OR TO ANY CIRCUMSTANCE OF THE EMPLOYMENT. PENDING FURTHER ADVICE, YOU MAY PROVIDE NECESSARY CONSERVATIVE TREATMENT IF YOU BELIEVE THE CONDITION MAY BE DUE TO THE INJURY OR TO THE EMPLOYMENT.

7. IF A DISEASE OR ILLNESS IS INVOLVED, OWCP APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS OBTAINED FROM

(Name of OWCP official)

8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)	9. TITLE
Lydia Cleghorne	RN
10. LOCAL EMPLOYING AGENCY TELEPHONE NUMBER	**11. DATE (mo., day, year)**
886-3938	4/13/78

12. SEND ONE COPY OF YOUR REPORT TO (Fill in address)	13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT.
U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Dept. or Agency Bureau or Office Local Address (Including Zip Code)

FORM CA-16
(REV. DEC. 1974)

PART B – ATTENDING PHYSICIAN'S REPORT

14. EMPLOYEE'S NAME (Last, first, middle)
Jenkins, Shirley A.

15. WHAT HISTORY OF INJURY OR DISEASE DID EMPLOYEE GIVE YOU?
Stepped in hole crossing street injuring left ankle

16. IS THERE ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE, OR PHYSICAL IMPAIRMENT? (If yes, please describe)
☐ Yes ☑ No

17. WHAT ARE YOUR FINDINGS (include results of x-rays, laboratory tests, etc.)?
frx left ankle

18. WHAT IS YOUR DIAGNOSIS?
frx left ankle, contusion

19. DO YOU BELIEVE THE CONDITION FOUND WAS CAUSED OR AGGRAVATED BY THE EMPLOYMENT ACTIVITY DESCRIBED? (Please explain your answer if there is doubt.)
☑ Yes ☐ No

20. DID INJURY REQUIRE HOSPITALIZATION? ☐ Yes ☑ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ Yes ☐ No

22. SURGERY (If any, describe type)

23. DATE SURGERY PERFORMED (mo., day, year)

24. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
Short leg cast, medication

25. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?

26. DATE OF FIRST EXAMINATION (mo., day, year)
4/12/78

27. DATE(S) OF TREATMENT (mo., day, year)

28. DATE OF DISCHARGE FROM TREATMENT (mo., day, year)

29. PERIOD OF DISABILITY (If termination date unknown, so indicate) (mo., day, year)
TOTAL DISABILITY: FROM 4/12/78 TO unknown
PARTIAL DISABILITY: FROM TO

30. DATE EMPLOYEE ABLE TO RESUME WORK (mo., day, year)
LIGHT WORK not known
REGULAR WORK

31 IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☑ NO IF YES, FURNISH DATE ADVISED (month, day, year)

32. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK, THAT COULD REASONABLY BE PERFORMED WITH THESE LIMITATIONS.
N/A

33. GENERAL REMARKS AND RECOMMENDATION FOR FUTURE CARE, IF INDICATED.
will reexamine cast in 6 to 8 wks.

34. DO YOU SPECIALIZE? ☑ Yes ☐ No (If yes, state specialty) orthopedics

35. SIGNATURE OF PHYSICIAN
Ralph Jones, MD

36. ADDRESS (Number, street, city, state, zip code)
417 So. Michigan
Suite 800
Chicago Ill 60609

37. PHYSICIAN'S SOCIAL SECURITY NUMBER
4-6132

38. DATE OF REPORT (mo., day, year)
4/14/78

39. MEDICAL BILL. Charges for your services may be presented in the space below or on your billhead stationery.

Date or period of treatment	Service or supplies must be itemized	Quantity or number	Unit price: Cost	Unit price: Per	Amount: $	Amount: ¢
	TOTAL					

U.S. GOVERNMENT PRINTING OFFICE : 1979 O—305-869

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE (Last, first, middle): Jenkins, Shirley A

2. HOME MAILING ADDRESS (Number, Street, City, State, Zip Code): 2110 So. Damen Chicago Ill 60608

3. DATE AND HOUR OF INJURY (Mo., Day, Year): 4/12/78 9:30 ☑ AM ☐ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., Day, Year): 4/12/78 FROM TO ?

5. WHAT HISTORY OF INJURY (Including disease caused by the employment) DID EMPLOYEE GIVE YOU?
While crossing street to deliver mail stepped in a hole twisting left ankle

6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
Fx Left ankle

7. WHAT IS YOUR DIAGNOSIS?
Fx left ankle, contusion

8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts)
☑ YES ☐ NO

DID INJURY REQUIRE HOSPITALIZATION? ☑ YES ☐ NO
IF YES, DATE OF ADMISSION (Mo., Day, Year)
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ YES ☐ NO

11. OPERATIONS (If any, describe type)

12. DATE OPERATIONS PERFORMED (Mo., Day, Year)

13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
Short leg cast, medication

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?

15. DATE OF FIRST EXAMINATION (Mo., Day, Year): 4/12/78

16. DATES OF TREATMENT (Mo., Day, Year): Emergency Rm

17. DATE OF DISCHARGE FROM TREATMENT (Mo., Day, Year): not known

18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year)
TOTAL DISABILITY: FROM 4/12 TO not known
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME (Mo., Day, Year)
LIGHT WORK not known
REGULAR WORK

20. ADVISE IF EMPLOYEE IS ABLE TO RESUME WORK. ☐ YES ☐ NO IF YES, FURNISH DATE ADVISED.

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE/SHE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.
No work

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.
Return appt in 6 wks

23. SIGNATURE OF PHYSICIAN: Ralph Dauerk, MD

24. ADDRESS (Number, Street, City, State, Zip Code): Orthopedics

25. DATE OF REPORT (Mo., Day, Year): 4/14/78

CA-20
(REV. AUG. 1976)

best copy available

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES
Presbyterian St. Lukes Hospital
1735 W. Harrison, Chicago, IL 60608

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Jenkins, Shirley	4/12/78	Letter Carrier	438-78-2136

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
Pt stepped in a hole while crossing street

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS
Pt delivers letters and cards by foot door to door

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day)*

HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency *(Provide frequency, i.e., number of times or hours per day, in appropriate box).*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to ~~50~~ POUNDS 35 lbs			✓
HEAVY – LIFTING ~~50~~ to ~~100~~ POUNDS 70 lbs	✓		
PULLING/PUSHING, CARRYING			✓
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (HOURS)			✓
STANDING (HOURS)			✓
SITTING (HOURS)		✓	
STOOPING (HOURS)	✓		
KNEELING (HOURS)	✓		
REPEATED BENDING (HOURS)	✓		
CLIMBING (HOURS)			✓
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:	✓		

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in Item 7)*? ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			
LIGHT – LIFTING 10 to 20 POUNDS			
MODERATE – LIFTING 20 to 50 POUNDS			
HEAVY – LIFTING 50 to 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS
Left ankle frx w/l. contusion

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*
TOTAL DISABILITY FROM 4/12 TO 6 to 8 wks
PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*
LIGHT WORK ☐
REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY
frx Left ankle pt placed in a plast leg cast and provided crutches for ambulation

17. DATE OF EXAMINATION 4/12/78

18. DATES OF FURTHER APPOINTMENTS, IF ANY 2

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN
Ralph Jansen, MD

20. PROFESSIONAL DEGREE
Orthopedics

21. DATE *(Mo., day, year)*
4/14/78

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U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS

ATTENDING PHYSICIAN'S REPORT

1. NAME OF INJURED EMPLOYEE (Last, first, middle): Jenkins, Shirley A.

2. HOME MAILING ADDRESS (Number, street, city, state, zip code): 3110 So. Damen, Chicago, Ill. 60608

3. DATE AND HOUR OF INJURY (Mo., day, year): 4/12/78 9:30 ☒ AM ☐ PM

4. PERIOD COMPENSATION IS CLAIMED AS A RESULT OF PAY LOSS (Mo., day, year): FROM 4/?8 TO present

5. WHAT HISTORY OF INJURY (including disease caused by the employment) DID EMPLOYEE GIVE YOU?
Stepped in hole crossing street

6. WHAT ARE YOUR FINDINGS (Include results of x-rays, laboratory tests, etc.)?
fx left ankle contusion; fx

7. WHAT IS YOUR DIAGNOSIS?
ligament instability subsequent to L ankle fx

8. DO YOU BELIEVE THIS DISABILITY IS IN ANY WAY RELATED TO THE HISTORY OF THE INJURY AS GIVEN ABOVE? (Please explain your answer if there are doubts)
☒ YES ☐ NO

DID INJURY REQUIRE HOSPITALIZATION? ☐ YES ☒ NO
IF YES, DATE OF ADMISSION (Mo., day, year)
DATE OF DISCHARGE

10. IS ADDITIONAL HOSPITALIZATION REQUIRED? ☐ YES ☐ NO

11. OPERATIONS (If any, describe type): —

12. DATE OPERATIONS PERFORMED (Mo., day, year)

13. WHAT (Other) TYPE OF TREATMENT DID YOU PROVIDE?
conservative cast - clmt may need surgery if instability persists

14. WHAT PERMANENT EFFECTS, IF ANY, DO YOU ANTICIPATE?
>

15. DATE OF FIRST EXAMINATION (Mo., day, year): 4-12-78

16. DATES OF TREATMENT (Mo., day, year): 5/30/78 6/13/78

17. DATE OF DISCHARGE FROM TREATMENT (Mo., day, year)

18. PERIOD OF DISABILITY (If termination date unknown - so indicate) (Mo., day, year)
TOTAL DISABILITY: FROM 4/12 TO ?
PARTIAL DISABILITY: FROM TO

19. DATE EMPLOYEE ABLE TO RESUME (Mo., day, year)
LIGHT WORK
REGULAR WORK

20. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE BEEN ADVISED? ☐ YES ☒ NO IF YES, FURNISH DATE ADVISED.

21. IF EMPLOYEE IS ABLE TO RESUME ONLY LIGHT WORK, INDICATE THE EXTENT OF HIS PHYSICAL LIMITATIONS AND THE TYPE OF WORK HE COULD REASONABLY PERFORM WITH THESE LIMITATIONS.
Pt. to return from work - ambulates with the aid of crutches

22. GENERAL REMARKS AND RECOMMENDATIONS FOR FUTURE CARE, IF INDICATED.
Pt re-casted Will see again in 4 wks

23. SIGNATURE OF PHYSICIAN: Ralph Tausek MD

24. ADDRESS (Number, street, city, state, zip code): Orthopedics

25. DATE OF REPORT (Mo., day, year): 6/13/78

CA-20
Rev. Feb. 1975

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
Office of Workers' Compensation Programs (OWCP)

CLAIM FOR COMPENSATION ON ACCOUNT OF TRAUMATIC INJURY

PART A – EMPLOYEE'S STATEMENT

1. Name of Injured Employee *(Last, first, middle)*: Jenkins, Shirley A.

2. Social Security Number: 438-78-2136

3. OWCP File Number *(If known)*: A10-30 7463

4. Is Claim Being Made For Wage Loss? ☑ Yes ☐ No

5. Is Claim Being Made For Scheduled Award Based On Permanent Disability Involving Member, Organ Or Function of Body? ☐ Yes ☑ No

6. Period Compensation Is Claimed As A Result Of Wage Loss *(Mo., day, year)*: From: 4/28/78 Through: present

7. Has Any Pay Been Received For The Period Shown In Item 6? ☐ Yes ☑ No If Yes, State Full Amount And Inclusive Dates For Such Period *(Mo., day, year)*: $ _____ From: _____ Through: _____

8. Has A Claim Been Made Against Any Third Party Responsible For The Injury? ☐ Yes ☑ No
If Yes, Give Name And Address Of Such Party Or Insurance Carrier

9. Status Of Third Party Claim/Amount Of Recovery

10. Were You Ever In The Armed Forces Of The United States? ☐ Yes ☑ No If Yes, Furnish →
a. Service Number
b. Branch Of Service
c. Period Of Service *(Mo, day, year)* From: _____ Through: _____

11. If Answer To Item 10 Is Yes, Have You Applied For Or Received Benefits From The Veterans Administration Based On Such Service? ☐ Yes ☑ No If Yes, Furnish →
a. Claim Number
b. Address of VA Office Where Claim Is Filed
c. Nature Of Disability And Monthly Payment

12. Have You Applied For Or Received An Annuity Under The U.S. Civil Service Retirement Act Or Any Other Federal Retirement Or Disability Law? ☐ Yes ☑ No If Yes, Furnish →
a. Claim Number
b. Date Annuity Began *(Mo., day, year)*
c. Amount of Monthly Payment $ _____

13. List Your Dependents

Name	Relationship	Date Of Birth	Living With You? *(Yes/No)*	Mailing Address, If Different From Your Own
Jessie Jenkins	husband	5/16/45	yes	

14. Show Amount Paid Each Month For Support Of Dependents Not Living With You. Give Dependents' And Payees' Names And Addresses And State Whether Such Payments Were Ordered By A Court. If Support Was Ordered By A Court, Attach A Copy Of The Order.

I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled because of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement above is true to the best of my knowledge and belief.

15. Employee's Signature: Shirley A. Jenkins

16. Employee's Home Mailing Address *(Include Zip Code)*: 2110 S Damen Chicago Ill 60608

17. Date *(Mo., day, year)*: 6/13/78

Form CA-7
Feb. 1975

STATEMENT OF OFFICIAL SUPERIOR

PART B – GENERAL

18. Name and Address of Reporting Office *(Number, street, city, state, zip code)*
Chicago Main Post Office. 433 W Van Buren Chicago Ill 60607

19. Pay Rate As Of:	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
Date of Injury →	$ 29,500 per yr.	$ per	$ per	$ per
Date Employee Stopped Work →	$ 29,500 per yr.	$ per	$ per	$ per

20. If Employee Received Additional Pay, i.e. Premium, Sunday, Night Differential, Identify Type And Show Amount
Type N/A $ _____ per _____

21. Show Work Week When Pay Stopped If Other Than Monday Through Friday
S M T W T F S

22. Did Employee Work In The Position Held At The Time of Injury A Full Eleven Months Immediately Prior To The Injury?
☒ Yes ☐ No

23. If Answer To 22 Is No, Would The Position Have Provided Employment For Eleven Months, Except For The Injury?
☐ Yes ☐ No

24. Total Length of Employee's Federal Civilian Service
2 yrs 8 mos

25. Inclusive Dates Employee Received Leave Pay For Any Part of The Period Since Stopping Work

a. Annual Leave	b. Sick Leave	c. Other *(Specify)*

PART C – CONTINUATION OF PAY

26. Pay Rate Used For "Continuation of Pay" Purposes
$29,500 per yr.

27. Inclusive Dates Regular Pay Continued During Period of Disability, Do Not Include Periods of Sick or Annual Leave
From: 4/13/78 Through: 5/27/78

28. Gross Dollar Amount of Regular Pay Which Employee Received During Period of Disability. Do Not Include Pay Received For Sick or Annual Leave
$2,785.00

29. If Pay Rate Changed While The Employee Was Receiving Continuation of Pay, Show Date of Change And New Rate *(Mo., day, year)*	a. Base Pay	b. Subsistence	c. Quarters	d. Other *(Specify)*
	$ per	$ per	$ per	$ per

PART D – COMPENSATION

30. Date And Hour All Pay Terminated *(Mo., day, year)*
5/28/78 ☐ AM ☐ PM

31. Period For Which Compensation Is Claimed
From: 5/28/78 Through: present

32. Deductions:

	Health Benefits	Optional Insurance
a. Was Employee Enrolled On Date Pay Stopped?	☒ Yes ☐ No	☒ Yes ☐ No
b. If Yes, Furnish Code Number.	2 0 2	
c. If Yes, Give Date Through Which Deductions Were Last Made.		

PART E – RETURN TO DUTY

33. Date And Hour Returned To Work *(Mo., day, year)*
hasn't returned ☐ AM ☐ PM

34. Pay Rate At Time Returned To Work
$ _____ per _____

35. Show Work Week On Return To Work If Other Than Monday Through Friday
S M T W T F S

36. If Work Assignment Has Been Changed Because of Disability Resulting From The Injury, Describe Type of Work Employee Is Now Performing.

PART F – CERTIFICATION

37. I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exceptions:

38. Signature of Supervisor	39. Title And Office Phone Number	40. Date *(Mo., day, year)*
Carmen Velez	ICS 886-5035	6/15/78

PERFORMANCE TEST
JENKINS CASE
TASK I

September 12, 1982

To Whom It Concerns:

REF: Shirley A. Jenkins

I examined Ms. Jenkins today, she still has some left ankle instability but she has adapted well to this impairment. Exam today reveals no swelling or discoloration. Xrays reveal a well healed fracture; at posterior deltoid site. Range of Motion was full and uninhibited with moderate tenderness in the colateral alignment. Left ankle resistant test both posteriorly and anteriorly was within normal limits. Ms. Jenkins continues to demonstrate an atolic gait on the left, and continues in physical therapy at this time.

She is not ready to return to full time work.

Sincerely,

Ralph Fausek, M.D.
Orthopedics Unlimited

PERFORMANCE TEST
JENKINS CASE
TASK I

23. Do you have sufficient information needed to determine if Shirley Jenkins can now return to her regular job (as stated in the position description?) On your Answer Sheet, mark the best answer.

    a. Yes

    b. No

24. Based on your answer to the previous question, what is most important to do next? Select the best answer below and mark it on your Answer Sheet:

    a. Request a medical report indicating the long term prognosis for her disability.

    b. Request a medical report detailing the treatment provided.

    c. Request a reasoned medical opinion as to whether the current disability is job related.

    d. Request current work limitations.

    e. You have the information you need and have determined that she can return to regular duty.

    f. You have the information you need and have determined that she cannot return to regular duty.

PERFORMANCE TEST
JENKINS CASE
TASK II

Review the CA-17 and medical report on pages 94 - 96.
Then turn to page 97 and answer the questions.

OMB No. 1215-0103 –Exp. 9-30-82

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

The following request for information is authorized by law (5 USC 8101 et seq.) Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108.

PART A – SUPERVISOR

1. NAME AND ADDRESS OF THE MEDICAL FACILITY AUTHORIZED TO PROVIDE MEDICAL SERVICES
Presbyterian St. Lukes Hospital
1735 W. Harrison, Chicago Ill 100608

2. EMPLOYEE'S NAME (Last, first, middle)	3. DATE OF INJURY (Mo., day, year)	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
Jenkins, Shirley	4/12/78	Letter Carrier	438-78-2136

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
Slipped in a hole while crossing street

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS
Delivers letter by foot from door to door

a. EXPOSURE (Check applicable exposure and fill in number of hours of exposure each work day)

HEAT ✓ COLD ✓ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (Provide frequency, i.e., number of times or hours per day, in appropriate box).

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS 35 lbs			✓
HEAVY – LIFTING 50 to 100 POUNDS 70 lbs.	✓		
PULLING/PUSHING, CARRYING			✓
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (HOURS)			✓
STANDING (HOURS)			✓
SITTING (HOURS)		✓	
STOOPING (HOURS)	✓		
KNEELING (HOURS)	✓		
REPEATED BENDING (HOURS)	✓		
CLIMBING (HOURS)			✓
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:			

8. SEND A COPY OF THIS REPORT TO:

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to the OWCP (as shown in item 8).

Form CA-17
Rev. July 1981

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)?* ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. **IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY.** *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS		✓	
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING	✓		
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (2 HOURS)		✓	
STANDING (2 HOURS)		✓	
SITTING (HOURS)			✓
STOOPING (2 HOURS)		✓	
KNEELING (HOURS)		✓	
REPEATED BENDING (2 HOURS)	✓		
CLIMBING (2 HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:			

EXPOSURE LIMITATIONS *(Specify)*:

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

limited flex of left ankle

13. PERIOD OF DISABILITY *(if termination date unknown, so indicate)*

TOTAL DISABILITY FROM TO

PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*

LIGHT WORK ☐

REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. **IF YES, FURNISH DATE ADVISED** *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY

limited flexibility of left ankle

17. DATE OF EXAMINATION

18. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

Ralph Jarnick M.D.

20. PROFESSIONAL DEGREE

orthopedics

21. DATE *(Mo., day, year)*

8/3/84

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PERFORMANCE TEST
JENKINS CASE
TASK II

August 4, 1984

To Whom It Concerns:

REF: Shirley A. Jenkins

I examined Ms. Jenkins today. She still has some left ankle instability but she has adapted well to this impairment. Range of motion was full and uninhibited with moderate tenderness in the colateral alignment. Left ankle resistant test both posteriorly and anteriorly was within normal limits. Ms. Jenkins continues to demonstrate an atolic gait on the left. The ankle appears to have stablized at what may be maximal improvement.

Sincerely,

Ralph Fausek, M.D.
Orthopedics Unlimited

PERFORMANCE TEST
JENKINS CASE
TASK II

On the Answer Sheet mark the letter of the best answer:

25. a. You do not have the information needed to determine if Shirley Jenkins can return to a job as letter carrier - you need to know what the long term prognosis is.

    b. You do not have the information needed to make the determination - you need a reasoned medical opinion as to whether the current disability is job-related.

    c. You do have the information needed - you have determined that she is able to return to her old job as stated in the position description.

    d. You do have the information needed - you have determined that she is not able to return to her old job.

26. How would you attempt to resolve Shirley Jenkins' case? On the Answer Sheet mark the letter of the best answer:

    a. Offer her a job accommodating her limitations.

    b. Request a second medical opinion on her work limitations.

    c. Request termination of compensation.

    d. Request an LWEC rating.

PERFORMANCE TEST
JENKINS CASE
TASK III

Read the attached job description for a distribution clerk on page 99 and the work restrictions for Shirley Jenkins on page 100. Then answer the answer the questions on page 101.

TITLE: DISTRIBUTION CLERK
POSITION NUMBER: KP-12
LEVEL: PS-5
OCCUPATIONAL CODE: 2315-04

BASIC FUNCTION: Separates mail in a post office, terminal, airmail field, or other postal facility in accordance with established schemes, including incoming or outgoing mail or both.

DUTIES AND RESPONSIBILITIES

(A) Makes primary and one or more secondary distributions of incoming mail by delivery point (for example, classified or contract station or branch or other delivery unit, general delivery, lockboxes, rural or star route, or city carrier route) based on a knowledge of the distribution scheme established for that office.

(B) Makes primary and one or more secondary distributions of outgoing mail for dispatch (for example, by city, state, region, train, highway or railway post office or airmail flight) based on a knowledge of the distribution scheme prescribed by the Postal Transportation Service.

(C) In addition, may perform any of the following duties:

1. Maintains records of mails.
2. Examines balances in advance deposit accounts.
3. Faces and cancels mail.
4. Ties mail and inserts facing slips.
5. Opens and dumps pouches and sacks.
6. Operates cancelling machines.
7. Records and bills mail (for example, c.o.d. registered, and so forth) requiring special service.
8. Renders service at public windows.

ORGANIZATIONAL RELATIONSHIPS: Reports to a foreman or other designated supervisor.

PHYSICAL REQUIREMENTS

(A) Must be physically able to perform efficiently the duties of the position which require arduous exertion involving prolonged standing, walking, distributing, and reaching, and may involve the handling of heavy sacks of mail. On outside assignments this work is performed in all kinds of weather. In most instances, an amputation of arm, hand, leg, or foot will not disqualify an applicant for appointment, although it may be necessary that this condition be compensated by use of satisfactory prosthesis. The distant vision required must test 20/40 (Snellen) in one eye, glasses permitted. Generally, applicants must be able to hear ordinary conversation with or without a hearing aid but some positions may be filled by the deaf. Color vision is not required for these positions.

PART B – PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)?* ☐ YES ☑ NO
(If yes, indicate whether Part or Full-Time and date able to resume such work)

☐ PART TIME Hours a day ☐ FULL TIME *Date (Mo., day, year)*

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? ☐ NO ☐ YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

PHYSICAL LIMITATIONS	FULL RESTRICTION	PARTIAL RESTRICTION	NO RESTRICTION
SEDENTARY – LIFTING 0 to 10 POUNDS			✓
LIGHT – LIFTING 10 to 20 POUNDS			✓
MODERATE – LIFTING 20 to 50 POUNDS		✓	
HEAVY – LIFTING 50 to 100 POUNDS	✓		
PULLING/PUSHING, CARRYING	✓		
REACHING OR WORKING ABOVE SHOULDER			✓
WALKING (2 HOURS)		✓	
STANDING (2 HOURS)		✓	
SITTING (HOURS)			✓
STOOPING (2 HOURS)		✓	
KNEELING (HOURS)		✓	
REPEATED BENDING (2 HOURS)	✓		
CLIMBING (2 HOURS)	✓		
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.	✓		
OTHER:			
EXPOSURE LIMITATIONS *(Specify)*:			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

limited flex of left ankle

13. PERIOD OF DISABILITY *(If termination date unknown, so indicate)*

TOTAL DISABILITY FROM TO

PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*

LIGHT WORK ☐

REGULAR WORK ☐

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? ☐ YES ☐ NO. IF YES, FURNISH DATE ADVISED *(Mo., day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY

limited flexibility of left ankle

17. DATE OF EXAMINATION

18. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

Ralph Jarrett M.D.

20. PROFESSIONAL DEGREE

orthopedics

21. DATE *(Mo., day, year)*

8/3/84

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27. Based on your answer to the previous question, select the best answer below:

    a. The job is not within the imposed work limitations - it exceeds the requirements of no prolonged standing, bending and stooping.

    b. The job is not within the imposed work limitations - it exceeds the requirements of no prolonged standing, walking, lifting heavy sacks.

    c. The job is within the imposed work limitations - offer her a job.

PERFORMANCE TEST
REHABILITATION CASE

Review the file notes for 7 long-term cases on pages 103 - 109. Then go to page 110 for the question.

PERFORMANCE TEST
REHABILITATION CASE

FILE NOTES

Name:	William Leavis
Age:	61
Position held:	Truck Driver
Date of Injury:	11/6/79
Type of Injury:	Accident with truck, loss of right arm
Status:	Prosthetic Device on right arm
Education:	High School graduate
Previous Employment:	Truck driver for construction firm

PERFORMANCE TEST
REHABILITATION CASE

FILE NOTES

Name:	William Buzarski
Age:	48
Position held:	Truck Mechanic
Date of Injury:	3/6/79
Type of Injury:	Lower back strain
Status:	Severe degenerative disk disease, corrective surgery partially successful
Education:	High School graduate
Previous Employment:	None
Employment History:	Worked on light duty 6/1/79 - 2/17/80; left for spinal fusion surgery - did not return.

PERFORMANCE TEST
REHABILITATION CASE

FILE NOTES

Name:	Edgar Burrow
Age:	55
Position held:	Electrician
Date of Injury:	4/17/81
Type of Injury:	Metal beam fell on legs, mulitiple leg fracture
Status:	Must use cane, can walk only short distances, cannot stand continuously for more than 1 hour. Claimant also has moderately severe diabetic condition
Education:	H.S. graduate
Previous Employment:	Worked as a clerk in a hardware store for 4 years prior to becoming an electrician.

PERFORMANCE TEST
REHABILITATION CASE

FILE NOTES

Name:	John Lee
Age:	37
Position held:	Electrician
Date of Injury:	2/9/82
Type of Injury:	Lower back strain
Status:	Total disability, conservative treatment
Education:	Completed 10th grade
Previous Employment:	N.A.
Employment History:	-3 warning letters -1 suspension for 10 days - for abuse of sick leave

PERFORMANCE TEST
REHABILITATION CASE

FILE NOTES

Name:	Craig Forester
Age:	33
Position held:	Truck Mechanic
Date of Injury:	12/13/82
Type of Injury:	Broken hip and hand; tripped over piece of equipment while repairing truck
Status:	Loss of motion in right hip. Must use cane when walking; no prolonged walking or standing
Education:	High School graduate
Previous Employment:	2 years as auto mechanic

PERFORMANCE TEST
REHABILITATION CASE

FILE NOTES

Name:	Richard Leonard
Age:	49
Position held:	Construction Foreman
Date of Injury:	5/21/83
Type of Injury:	Herniated lumbar disc. Fell off scaffold of construction site
Status:	Confined to bed rest; medication
Education:	Completed 11th grade
Previous Employment:	4 years as road construction worker

PERFORMANCE TEST
REHABILITATION CASE

FILE NOTES

Name:	John Chandler
Age:	39
Postion held:	Engineering Technician (estimator)
Date of Injury:	9/23/80
Type of Injury:	Auto accident, severed spinal cord
Status:	Paraplegic, paralyzed from waist down, confined to wheel chair
Education:	2 years college: - Drafting - Engineering
Previous Employment:	Draftsman for engineering contractor

PERFORMANCE TEST
REHABILITATION CASE

28. Based on the evidence available, select the <u>three</u> people you consider to be the best candidates for successful rehabilitation. Mark the letters of your answer on the Answer Sheet.

    a. William Leavis

    b. William Buzarski

    c. Edgar Burrow

    d. John Lee

    e. Craig Forester

    f. Richard Leonard

    g. John Chandler

Pre Test Answer Sheet

Please Print

(Last 6 digits Soc. Sec. No.)

(Years Experience in Compensation)

(OWCP District Office)

(Test Date)

1. a|| b|| c||

2. a|| b|| c|| d||

3. a|| b|| c||

4. a|| b|| c|| d||

5. a|| b|| c||

6. a|| b|| c|| d||

7. a|| b||

8. a|| b|| c||

9. a|| b|| c|| d||
e||

10. a|| h|| o|| v|| cc||
b|| i|| p|| w|| dd||
c|| j|| q|| x||
d|| k|| r|| y||
e|| l|| s|| z||
f|| m|| t|| aa||
g|| n|| u|| bb||

11. a|| h|| o|| v|| cc||
b|| i|| p|| w|| dd||
c|| j|| q|| x||
d|| k|| r|| y||
e|| l|| s|| z||
f|| m|| t|| aa||
g|| n|| u|| bb||

12. a|| h|| o|| v||
b|| i|| p|| w||
c|| j|| q|| x||
d|| k|| r|| y||
e|| l|| s|| z||
f|| m|| t|| aa||
g|| n|| u|| bb||
cc||

13. a|| h|| o|| v||
b|| i|| p|| w||
c|| j|| q|| x||
d|| k|| r|| y||
e|| l|| s|| z||
f|| m|| t|| aa||
g|| n|| u|| bb||
cc||

14. a|| b|| c||

15. a|| b|| c|| d||

16. a|| b|| c|| d||

17. a|| b|| c|| d||

18. a|| b|| c||

19. a|| b|| c|| d|| e||

20. a|| b|| c|| d||

21. a|| b|| c|| d||

22. a|| b|| c|| d|| e||

23. a|| b||

24. a|| b|| c|| d||
e|| f||

25. a|| b|| c|| d||

26. a|| b|| c|| d||

27. a|| b|| c||

28. a|| b|| c|| d||
e|| f|| g||

Post Test Answer Sheet

Please Print

(Last 6 digits Soc. Sec. No.)

(Years Experience in Compensation)

(OWCP District Office)

(Test Date)

1. a|| b|| c||

2. a|| b|| c|| d||

3. a|| b|| c||

4. a|| b|| c|| d||

5. a|| b|| c||

6. a|| b|| c|| d||

7. a|| b||

8. a|| b|| c||

9. a|| b|| c|| d|| e||

10. a|| b|| c|| d|| e|| f|| g|| h|| i|| j|| k|| l|| m|| n|| o|| p|| q|| r|| s|| t|| u|| v|| w|| x|| y|| z|| aa|| bb|| cc|| dd||

11. a|| b|| c|| d|| e|| f|| g|| h|| i|| j|| k|| l|| m|| n|| o|| p|| q|| r|| s|| t|| u|| v|| w|| x|| y|| z|| aa|| bb|| cc|| dd||

12. a|| b|| c|| d|| e|| f|| g|| h|| i|| j|| k|| l|| m|| n|| o|| p|| q|| r|| s|| t|| u|| v|| w|| x|| y|| z|| aa|| bb|| cc||

13. a|| b|| c|| d|| e|| f|| g|| h|| i|| j|| k|| l|| m|| n|| o|| p|| q|| r|| s|| t|| u|| v|| w|| x|| y|| z|| aa|| bb|| cc||

14. a|| b|| c||

15. a|| b|| c|| d||

16. a|| b|| c|| d||

17. a|| b|| c|| d||

18. a|| b|| c||

19. a|| b|| c|| d|| e||

20. a|| b|| c|| d||

21. a|| b|| c|| d||

22. a|| b|| c|| d|| e||

23. a|| b||

24. a|| b|| c|| d|| e|| f||

25. a|| b|| c|| d||

26. a|| b|| c|| d||

27. a|| b|| c||

28. a|| b|| c|| d|| e|| f|| g||